Reset Form Print Form

Connecticut Department of Public Health AIDS Drug Assistance Program

Provider Certification Prior Authorization Form – Serostim®

A request for the patient identified below has been made for the dispensing of Serostim® (somatropin). The Department of Public Health requires more information before this prescription can be paid by the Connecticut AIDS Drug Assistance Program (CADAP). If approved, this prior authorization is good for six months from the initial fill date for a maximum of 1,344 units (48-week supply), regardless of dosage.

Please complete and return via fax to: 855-461-2759

Patient Information:

Last Name: **First Name:**

CADAP ID Number: **Date of Birth:** / /

Address:

City: **State:**

Home Phone: – – **Cell Phone:** – –

Healthcare Provider Information:

Last Name: **First Name:**

National Provider Identification (NPI) Number:

Address:

City: **State:**

Phone Number: – – **Fax Number:** – –

(Form continued on next page.)

Revised November 4, 2022

Provider Certification Prior Authorization Form – Serostim®

Patient's Last Name:	Patient's First Name:

Prescription Information:

Please fill out all questions completely and submit required clinical documentation where noted.

Dosing Recommendations: 0.1 mg/kg subcutaneous (SC) QD or QOD up to 6 mg per day

1. Drug Name: Serostim® (somatropin)
2. Drug Strength:
   - ☐ 4.0 mg vial
   - ☐ 5.0 mg vial
   - ☐ 6.0 mg vial
3. Directions:

_____

_____

Clinical Requirements:

4. Please document if this a request for initial therapy **or** continuation of therapy:

_____

5. Has the patient been diagnosed with acquired immunodeficiency syndrome (AIDS) and AIDS wasting syndrome (see chart on last page for reference)? ☐ Yes ☐ No
6. Has the patient tried and failed preferred CADAP formulary regimens of megestrol and dronabinol? ☐ Yes ☐ No

   If **Yes**, please provide prescribed date(s) for each trial and submit clinical documentation of failures with fax:

   _____
7. Is the patient continuing to use their prescribed anti-viral therapy? ☐ Yes ☐ No

   List current anti-viral therapy: _____
8. Has the patient been evaluated for and diagnosed with inadequate nutritional intake, malabsorption, and/or hypogonadism? ☐ Yes ☐ No
9. If the patient is hypogonadal, has the patient been administered testosterone? ☐ Yes ☐ No

   If **Yes**, please attach documentation of administration.

(Form continued on next page.)

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Patient's Last Name:

Patient's First Name:

10. Has the patient had progressive weight loss greater than or equal to 10% of their body weight?

☐ Yes ☐ No

If **Yes**, please document the patient's two most recent body mass indexes (BMI) obtained within the last year:

BMI 1 and date taken: _____

BMI 2 and date taken: _____

11. Does the patient have a known hypersensitivity to growth hormone? ☐ Yes ☐ No

12. Are you requesting greater than 48 weeks of Serostim® therapy? ☐ Yes ☐ No

Note: If requesting greater than 48 weeks of Serostim therapy, you must supply sufficient clinical justification which will be forwarded to the ADAP Coordinator at the CT Department of Public Health.

Healthcare Provider Certification: I certify that I am a licensed healthcare provider with prescriptive authority and the information provided on this form is true, accurate, and complete. The issuance of the prescription is in compliance with the utilization criteria outlined on the back of this prior authorization form. I understand that if I provide false, fraudulent, and misleading information, that I face fines and penalties under State law.

_____ _____

Healthcare Provider's Signature ***NPI Number***

_____ _____

Date of Request ***Time of Request***

Provider Certification Prior Authorization Form – Serostim®

Clinical Requirements for Serostim®* under the CADAP [Somatropin (rDNA origin) for injection]

FOR REFERENCE ONLY* PLEASE DO NOT FAX THIS PAGE

Diagnostic Indications:

☐ Serostim® is indicated for the treatment of AIDS and AIDS wasting syndrome to increase lean body mass and body weight, and improve physical endurance.

Note: The package insert for Serostim indicates that there is no safety or efficacy data for continuous use of this medication beyond 48 weeks.

Patient MUST meet one of the following definitions of AIDS and AIDS wasting syndrome:

☐ 10% unintentional weight loss over 6 months;

☐ 7.5% unintentional weight loss over 3 months;

☐ 5% Body cell mass (BCM) loss within 30 days; **OR**

☐ BMI < 20 kg/m^2.

Contraindications:

☐ Serostim® should not be used in patients with acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure.

☐ Serostim® is contraindicated in patients with active neoplasia (either newly diagnosed or recurrent). Any anti-tumor therapy should be completed prior to starting therapy with Serostim®.

Other:

☐ Optimal nutrition is essential to keep up with the increased caloric demands and to decrease the rate of catabolism.

☐ Patient must be on proper antiretroviral therapy to control viral load.

Dosage:

Weight Range	Dose
> 55kg (> 121 lb.)	6.0 mg* SC daily
45–55 kg (99–121 lb.)	5.0 mg* SC daily
35–45 kg (75–99 lb.)	4.0 mg* SC daily; 8.8 mg* SC daily
< 35 kg (< 75 lb.)	0.1 mg/kg SC daily

**Based on an approximate daily dosage of 0.1 mg/kg.*

UPON COMPLETION, PLEASE RETURN VIA FAX TO: 855-461-2759

The fax machine is in a secured location as required by HIPAA regulations.

For any questions, please call Magellan Rx Management Pharmacy Unit at: 800-424-3310