



Physician SEROSTIM® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at 877-693-8280 or urgent requests to 877-693-8476. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 800-578-0898. Form must be completed for processing

Patient Name: \_\_\_\_\_ Plan ID#: \_\_\_\_\_
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Phone #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician Signature \_\_\_\_\_

Deliver to:
[ ] Physician's Office [ ] Patient's Home [ ] Patient filling at local Pharmacy (Name) \_\_\_\_\_ Fax: \_\_\_\_\_

To be Administered from: \_\_\_\_\_ to \_\_\_\_\_ or on: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Sig (How Administered): \_\_\_\_\_ ICD-9 Diagnosis Code: \_\_\_\_\_

Provide documentation (Attach BIA analysis report) of Body Impedance Analysis (BIA) including Body Cell mass and BMI.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lb \_\_\_\_\_ kg

- 1. Does the member currently have HIV/AIDS? (please circle) YES NO
If YES, please attach documentation from an infectious disease doctor indicating that the member is receiving optimal antiviral therapy or recent (within the past 2 months) laboratory documentation indicating plasma HIV RNA of less than 50 copies/ml:
2. Does the member currently have cancer (excluding Karposi's sarcoma)? (please circle) YES NO
If YES, please explain
3. Does the member currently have any symptomatic, opportunistic infections causing GI distress (e.g. diarrhea, N/V, etc.)? (please circle) YES NO
If YES, please explain
4. Is the member currently receiving nutritional support to reach nutritional goals? (please circle) YES NO
If YES, please explain (e.g. oral/liquid supplement, provided meal assistance, etc.)
5. Does the member currently have any psychiatric disorders (e.g. anxiety, depression, etc)? (please circle) YES NO
If YES, please document treatment
6. Is the member currently receiving an anabolic medication (Oxandrin, Winstrol, Nandrolone) AND an appetite stimulant (Marinol or Megace)? (please circle) YES NO
If NO, please explain (e.g. Is there a medical reason for not taking both these medications?)
7. For males, is the member currently receiving testosterone replacement therapy? (please circle) YES NO
If NO, please attach current documentation (lab result within the past 2 months) of normal testosterone blood levels.