

Physician SEROSTIM® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at **866-533-5498** or urgent requests to **866-546-7972**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-205-0749**. *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: _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

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 Kaposi'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.