

Physician SEROSTIM® Request Form

Fax non-urgent requests to PerformRx Pharmacy Services at 866-369-6038 or urgent requests to 866-533-5491. 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 866-533-5490. Form must be completed for processing.



Patient Name: _____
Address: _____
City: _____ State: _____
Phone #: _____

Plan ID#: _____
Apt # or Suite #: _____
Zip Code: _____
Birth date: _____

Physician Name: _____
Address: _____
City: _____ State: _____
Contact Person: _____ Phone #: _____

NPI #: _____
Apt # or Suite #: _____
Zip Code: _____
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.