South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Serostim® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ HIV infection/AIDS wasting

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is Serostim prescribed by or in consultation with an infectious disease specialist? ❑ **Yes** ❑ **No**

Has the patient tried and had an inadequate response or intolerance to dronabinol or megestrol? ❑ **Yes** ❑ **No**

Is the patient currently receiving treatment with antiretrovirals? ❑ **Yes** ❑ **No**

Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or those with acute respiratory failure? ❑ **Yes** ❑ **No**

Has the patient been screened to verify the absence of any active malignancy? ❑ **Yes** ❑ **No**

Does the patient have active proliferative or severe non-proliferative diabetic retinopathy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.