ARIZONA AIDS DRUG ASSISTANCE PROGRAM (ADAP)
SEROSTIM Prior Authorization Form

Please complete all of the following Patient/Physician information:

Patient Name: (Please Print)_____Patient Phone: (__)_____

Patient Address:_____

List Patient Allergy (if any):_____

Patient Date of Birth:_____

Provider Name:_____ Provider Specialty:_____

Provider Phone#: (__)_____ Provider Fax: (__)_____

Provider DEA #:_____ Provider NPI#:_____

Drug Requested: _____ *Strength:*_____*Frequency:*_____ *Qty*_____

☐ New Medication
☐ Ongoing Therapy If Ongoing, provide date started:_____
If Ongoing, did member show improvement with while on therapy?_____

MEDICAL HISTORY

Is the patient on and compliant with Antiretroviral medication? ☐ Yes ☐ No
Has the member tried and failed Marinol? ☐ Yes ☐ No
Has the member tried and failed Megace? ☐ Yes ☐ No
Does the member have a documented involuntary weight loss of at least 10% from baseline premorbid weight?
_____
Does the member have any type of active malignancy other than Kaposi's Syndrome? _____
If Yes, please specify the type of active malignancy:_____

Please list all other medications the member has previously tried or is currently using.

Name Strength Frequency Date of Trial List adverse reaction/side effects/reason for discontinuation

_____
_____
_____
_____
_____
_____
_____
_____

Please provide any additional information which should be considered in the space below:

_____
_____

Physician Signature: _____ Date _____

Please submit this form and any supporting documentations to the ADAP office by mail or fax (602-364-3263). If you have any questions, please call (602) 364-3610.