MARYLAND PHARMACY AND MEDICAL ASSISTANCE PROGRAMS
Tel # 410-767-1693- Fax# 410-333-7049

PRESCRIBER'S STATEMENT OF MEDICAL NECESSITY
Serostim® for Treatment of AIDS Wasting Syndrome
Patient Information

Patient name:_____ Address:_____
MA ID#:_____ _____
Tel #: (_____)_____-_____ _____
Date of birth:_____Height_____ft_____inch (not covered for pediatric patients)
Current weight:_____lbs or _____kg Date of measurement:_____/_____/___
Premorbid body weight:_____lbs or _____kg; Date of measurement:____/_____/____
Weight loss:_____lb (Pre-morbid body weight - Current Weight)
Percentage of weight loss:_____% (**at least 10**% weight loss over 12 months)
Above referenced patient:

* has clearly documented HIV infection/ has been diagnosed with AIDS Wasting: Yes__No__
* is currently receiving antiviral therapy: Yes__ No__ List current antiviral therapy in use: _____
* is receiving adequate intake on current nutrition regimen: Yes___ No___
* has tried appetite stimulants: Yes__ No__; List all appetite stimulants tried before growth hormone therapy:_____

Is patient testosterone deficient? Yes_____No_____
List other nutritional interventions/response:_____
Inadequate or no weight gain ____ Inadequate or no increase in lean body mass ____
Has patient been on Serostim® before? Yes___No__. If yes, date of last injection: _____
For both 1st & 2nd course of Serostim®, submit copy of bioelectric impedance analysis if available. For a 2nd course of Serostim®, which is currently not FDA, approved, submit letter of recommendation by an HIV infectious disease specialist.

Prescription

Rx Serostim® (somotropin) ___ mg daily SQ at hs- Max length of therapy = 12 weeks
Dispense: #___vials* ___4mg vials; ___5mg vials; __ 6mg vials
Recommended dosage guidelines:
<35kg = 0.1mg/kg/day ; 35-45 kg = 4mg ; 45-55 kg = 5mg ; >55kg = 6mg
Due to the drug's high cost, only one two-week supply at a time is authorized by the Department, up to a maximum of 12 weeks of therapy. If patient continues to lose weight at week Two, reevaluate for concurrent opportunistic infections/other clinical events. Stop therapy**.**

I certify that this treatment is medically necessary and meets the FDA-approved Serostim® labeled use guidelines. Supporting documentation in the patient's medical record is available for State audits.
_____Prescriber's address:_____
Prescriber's signature _____
Name:_____MD Date:_____Tel#: (_____)_____-_____
Specialty: _____License #_____ Fax# (_____)_____-_____
_____
Pharmacy name:_____
Phone #: (_____)_____-_____ Fax # (_____)_____-_____

* Adapted from Treatment Guidelines for HIV-Associated Wasting developed by the Consensus Development Panel, which met in New York City, NY, July 26, 2000.
* Implemented 2/20/01