Alabama Medicaid Pharmacy
Growth Failure for AIDS Wasting PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210 Auburn,
AL 36831-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Address _____ Phone # with area code _____

City/State/Zip _____ Fax # with area code _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Practitioner Signature Date

PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

NDC # _____ J Code _____ (if applicable) Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

DRUG/CLINICAL INFORMATION

❒ Initial request ❒ Renewal (Documentation of weight gain or stabilization must be included to continue therapy)

Drug requested _____ Proposed duration of therapy _____

Strength/Quantity _____ Daily dose _____

Height _____ Weight _____ BMI _____

Diagnosis _____ **ICD-9 Code** _____

1. Is there documentation of unintentional weight loss and loss of muscle mass due to AIDS wasting? ❒ Yes ❒ No
2. Is there documentation of a failed trial with appetite stimulants or weight gain agents? ❒ Yes ❒ No
3. Has the patient been on anti-retroviral therapy for the past 120 days? ❒ Yes ❒ No
4. Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No
5. If a history of malignancy exists, has patient been free of recurrence for at least the past 6 months? ❒ Yes ❒ No

   If any of the above is answered NO, request will be denied.
6. Does the patient have any of the following contraindications? Check all that apply.
   - ❒ Pregnancy
   - ❒ Proliferative or preproliferative diabetic retinopathy
   - ❒ Pseudotumor cerebri or benign intracranial HTN

   If any of the above contraindications apply, the request will be denied.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour