

**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 36832-3210**

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 _____ Qty. requested per month _____
if applicable

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 _____