Alabama Medicaid Pharmacy
Growth Failure for AIDS Wasting PA Request Form

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.

PHARMACY INFORMATION

Dispensing pharmacy ______________________ NPI # _________________________
NDC# ___________________________ J Code ___________________________ 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 KEPRO USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified
Comments _____________________________

Reviewer’s Signature ___________________________ Response Date/Time ___________________________

Alabama Medicaid Agency
www.medicaid.alabama.gov
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