



California ADAP Supplemental Form for Serostim Use

TELEPHONE: 888-311-7632 FAX: 800-848-4241

The ADAP Medical Advisory Committee has determined the criteria for use of growth hormone. Growth hormone (SEROSTIM only) is restricted to use in the treatment of AIDS WASTING SYNDROME. It is not covered by ADAP for treatment of lipodystrophy or HIV Adipose Redistribution Syndrome (HARS) in the absence of HIV-wasting. Treatment can be approved for a 12-week course of therapy only and must be dispensed in 4-week increments. The patient must be notified of Serostim dispensing restrictions at the time of initial dispensing: 1) maximum dispensing quantity of 4-week supply; 2) required re-evaluation of weight loss at specified refills to confirm that weight loss has stopped.

Complete the appropriate section listed below for determination of treatment authorization. CD4, Viral load and supporting lab documents are required. The committee also recommends the following:

- 1. Proper antiretroviral therapy to control viral load.
2. Nutrition consultation to assure adequate caloric intake and rule out malabsorption.

FORM "A" (INITIAL FILL)

Patient Name, Prescribing Physician, ADAP ID Code, Physician DEA #, DOB, Height, Physician Telephone #, Latest CD4 count & Viral Load, Physician Fax #, Date of results, Pharmacy Name, Signature of pharmacist or physician, Date, NABP #, Contact Person, Phone, Fax

Section 1 - Medical Justification Required For Questions 1-7 for Approval of Initial Prescription Only

- 1. Indicate diagnosis for use of Serostim:
2. Document one of the following criteria for use (ATTACH COPIES OF BIA RESULTS IF APPLICABLE*):
a. Body Cell Mass (BCM) loss of >= 5% over 6 months
b. In males, BCM < 35% of total body weight and Body Mass Index (BMI) < 27kg/m2
c. In females, BCM < 23% of total body weight and BMI < 27 kg/m2
d. BMI < 20 kg/m2
e. BMI >= 20 kg/m2 and < 25 kg/m2 AND
3. Documentation of a CD4 < 50
4. Has it been confirmed that there are no active malignancies, excluding Kaposi's sarcoma?
5. Is the patient hypogonadal?
6. Has the patient already failed an 8-week trial of anabolic steroids?
7. Is the Serostim dosing within the recommended guidelines for weight?

Refill Documentation - Medical Justification Required for Fill #2 (after 4 weeks), and Fill #3 (after 8 weeks).

- 1. Patient's current weight / date recorded:

RPHRx USE ONLY:

Approved, Denied, Fill # 1, 2, 3

By:

Date:



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1. Proper antiretroviral therapy to control viral load.
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FORM "B" (REFILLS ONLY)

Patient Name _____ <div style="display: flex; justify-content: space-between; font-size: small;"> Last Name First Name </div> ADAP ID Code _____ DOB _____ Height _____ Latest CD4 count & Viral Load _____ / _____ Date of results: _____ <i>Signature of pharmacist or physician</i> _____ <i>Date</i> _____	Prescribing Physician _____ Physician DEA # _____ Physician Telephone # _____ Physician Fax # _____ Pharmacy Name _____ NABP # _____ Contact Person _____ Phone (____) _____ Fax (____) _____
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Section 3 – Medical Justification Required for use WITHIN 6 months after completion of initial therapy (one of the following):

1. Document unintentional 5% loss of body weight, or BCM loss of $\geq 5\%$:
 Current weight/date recorded _____ / _____ Previous weight/date recorded _____ / _____
 Current BCM results/date recorded _____ / _____ Previous BCM results/date recorded _____ / _____
 (Attach copies of chart note documentation of weight loss or BIA results)
 2. In males, BCM <35% of total body weight and Body Mass Index (BMI) <27 kg/m² (Attach BIA results)
 3. In females, BCM <23% of total body weight and BMI <27 kg/m² (Attach BIA results)
 4. BMI <20 kg/m²
- Current BCM/date _____ / _____ Current BMI/date _____ / _____

Section 4 – Medical Justification Required for Repeating Therapy AFTER 6 Months of Completion of the Initial 12 Week Course

1. Confirm that patient has not reinitiated therapy within 6 months. When did patient complete last treatment course?
Date: _____
2. Complete Section 1 of Form "A".

Refill Documentation – Medical Justification Required for Fill #2 (after 4 weeks), and Fill #3 (after 8 weeks).

Patient's current weight / date recorded: _____ / _____

RPHRx USE ONLY:	Approved _____	Denied _____	By: _____	Date: _____
	Fill #	1 2 3		