AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

SEROSTIM REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

- ❑HIV with wasting or cachexia (concomitant antirviral therapy is necessary) ❑Other: _____
- Lean body mass (by BIA)_____kg Fat mass (by DXA)_____kg
- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Serostim** *Note: Serostim "every other day" injection should be considered in patients at increased risk for adverse effect related to recombinant human GH* QTY: _____ Refills:_____

- ❑4 mg/vial with sterile water for injection, USP
- ❑5 mg/vial with sterile water for injection, USP
- ❑6 mg/vial with sterile water for injection, USP

**Each vial of Serostim to be reconstituted with 0.5 to 1 mL of sterile water for injection, USP as directed by physician*

Daily dose based on patient's weight:

- ❑> than 55 kg (greater than 121 lb.), 6 mg SQ daily — QTY: 28 day supply Refills:_____
- ❑45-55 kg (99-121 lb.), 5 mg SQ daily — QTY: 28 day supply Refills:_____
- ❑35-45 kg (75-99 lb.), 4 mg SQ daily — QTY: 28 day supply Refills:_____
- ❑< 35 kg (< 75 lb.), 0.1 mg/kg SQ daily — QTY: 28 day supply Refills:_____
- ❑Other: _____ QTY: _____ Refills:_____

There are no safety and efficacy data available from controlled studies on continuous treatment for more than 48 weeks or intermittent treatment.

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

3.19.19