



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

October 29, 2009

Dear Prescriber:

The New York State Medicaid Pharmacy Program would like to offer information to providers detailing the process of obtaining a prior authorization when prescribing somatropin (Serostim®) for Medicaid and Family Health Plus enrollees.

Prior authorization for Serostim® is required to assure medical necessity and to deter the potential of drug diversion or illegal utilization. In processing your prior authorization, we understand that your time is valuable. Therefore, we can assure you that a prior authorization will be issued within 24 hours of receipt of all required information. Additionally, we monitor the Prior Authorization Call Center activity closely to ensure that your calls are answered promptly and are in line with our service level requirement of being answered within an average of thirty seconds.

The following is general information about Serostim® prior authorization requirements. This criteria has been developed in accordance with the manufacturer's product information and package insert. To ensure appropriate utilization, only prescribers (physicians, nurse practitioners and physician assistants), not their authorized agents, can initiate the prior authorization process for Serostim®:

- Call the toll free telephone number 1-877-309-9493 and respond to a series of questions. Fax requests are not permitted.
- Please be prepared to fax clinical documentation of amylase levels, creatinine levels, or fasting triglyceride levels. Submission of this documentation is **required** in order to obtain prior authorization of Serostim.
- Continuation beyond 28 days of therapy will require a new prescription and a new prior authorization number.
- No refills for Serostim® are allowed. To continue treatment, the patient must be re-examined and a positive therapeutic response documented. If a determination to continue Serostim® therapy is made, you will need to write a new prescription and obtain a new prior authorization number.
- If a patient has received a prior authorization for Serostim® recently, the prescriber will be informed of that issuance date. A new prior authorization for Serostim® will not be issued unless 75% of the previously authorized product has been used as determined by the issuance date of the previous prior authorization.
- The manufacturer's product information/package insert states "no significant additional efficacy was observed beyond 12 weeks." If a prescriber determines that continuation of Serostim® beyond 12 weeks/three prior authorizations is **medically necessary**, validating documentation must be available for review by the Medicaid Program when requested.

The enclosed CDRP Serostim® Prescriber Worksheet provides step-by-step assistance in completing the prior authorization process. This document is also available at: https://newyork.fhsc.com/providers/CDRP_forms.asp

If you have any questions or wish to obtain additional information, please contact the prior authorization clinical call center at 1-877-309-9493. Thank you for your continued support of our efforts to provide a quality pharmacy program for Medicaid and Family Health Plus enrollees.

Sincerely,

Linda J. Jones, R.N.
Director, Medicaid Pharmacy Program
Office of Health Insurance Programs

Enclosures (CDRP Criteria)

**NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION INSTRUCTIONS FOR PRESCRIBERS**

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309- 9493

PROGRAM INFORMATION

- ◆ Drugs included in the Clinical Drug Review Program require prior authorization.
- ◆ A list of CDRP drugs is available at www.nyhealth.gov and at <http://newyork.fhsc.com>.
- ◆ For some drugs subject to the CDRP, only the prescriber, not an authorized agent, can call the prior authorization call line to initiate a prior authorization.
- ◆ Fax requests are **NOT** permitted for the Clinical Drug Review Program.
- ◆ When calling the clinical call center, a pharmacy technician or a pharmacist will ask for specific clinical information.

PRESCRIBER PROCEDURE

- ◆ To initiate the prior authorization process, the prescriber must call the prior authorization phone line at **1-877-309-9493** and select **Option “1”** for Prescriber.
- ◆ Select **Option “1”** again to obtain a prior authorization for a CDRP drug. Please be prepared to provide the following information when calling:
 - ◆ Prescriber’s National Provider Identifier (NPI)
 - ◆ Enrollee’s ID number
 - ◆ CDRP drug name
- ◆ Each CDRP drug has specific clinical information that must be provided before a prior authorization will be issued. The clinical criteria relevant to each specific CDRP drug are listed at the end of the prior authorization worksheet.
- ◆ If uncertain which selection to make or if assistance with the prior authorization process is required, select **Option “3”** for assistance.
- ◆ Once authorization is given and a prior authorization number is obtained, the number must be written on the face of the prescription. Please be sure to include the “W” when writing the prior authorization number on the patient’s prescription.

For billing questions, call 1-800-343-9000
For clinical concerns or Clinical Drug Review Program questions, visit
www.nyhealth.gov and <http://newyork.fhsc.com> or call 1-877-309-9493
For Medicaid pharmacy policy and operations questions, call (518) 486-3209

**NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION WORKSHEET FOR PRESCRIBERS**

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309-9493

ENROLLEE INFORMATION			
Enrollee Name:		Street:	
Enrollee Medicaid ID#: (2 letters, 5 numbers, 1 letter)		City:	State: Zip:
PRESCRIBER INFORMATION			
Prescriber Name:		Contact Person:	
Prescriber 10-Digit National Provider Identifier (NPI) -----		Street:	
		City:	State: Zip:
		Office Phone#:	Office Fax #:
DIAGNOSIS AND MEDICAL INFORMATION			
Drug Name:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:	
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:			Date:
CLINICAL CRITERIA SPECIFIC TO A CDRP DRUG MUST BE COMPLETED FOR PRIOR AUTHORIZATION			
Clinical criteria relevant to each specific CDRP drug is available on the proceeding pages, and must be completed before prior authorization will be given.			
PRIOR AUTHORIZATION NUMBER			
Prior Authorization Number (11 digits): _____			

The attached mandatory Clinical Criteria must be completed before a prior authorization will be issued.

DO NOT FAX THIS FORM

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**NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION WORKSHEET FOR PRESCRIBERS**

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1-877-309-9493

ONLY PRESCRIBERS, NOT THEIR AUTHORIZED AGENTS, CAN INITIATE THE PRIOR AUTHORIZATION PROCESS FOR SOMATROPIN (SEROSTIM®)

CLINICAL CRITERIA

Somatropin:

Dose (based on weight, see chart below)	_____ mg SC daily
Day supply (maximum 28 days)	_____
Does patient have clearly documented HIV infection or AIDS?	
Is patient 18 years of age or older?	
Is patient receiving at least 100% of estimated caloric requirement on current nutritional regimen?	
Are you or have you consulted with an HIV specialist?	
Does the patient have unintentional weight loss of at least 5% or greater from baseline pre-morbid weight or weigh an amount that indicates a recent significant weight loss has occurred (BMI<20kg/m ²) in the absence of opportunistic infection?	
Is patient on current anti-viral therapy with good viral suppression?	
Does the patient have recent blood work to confirm an amylase level ≤ 3 times the upper normal limit, a creatinine level ≤ 2mg/dl or a fasting triglyceride level ≤ 500mg/dl?	
Does the patient have an active malignancy (other than Kaposi's Sarcoma) or are they undergoing systemic chemotherapy or being treated with interferon, anabolic steroids or investigational drugs?	
Does the patient have evidence of GI bleeding, intestinal obstruction, malabsorption syndrome, or severe liver dysfunction?	
Does the patient have angina pectoris, coronary artery disease, congestive heart failure, renal failure, or serious chronic anemia?	
Does the patient have a history of glucose intolerance or uncontrolled hypertension?	
Have other treatment modalities been tried and failed?	
Patient's current weight in pounds	_____ lbs
Patient's height in inches	_____ inches
Patient's current Body Mass Index (BMI)	_____

SEROSTIM DOSING CHART:

WEIGHT RANGE	APPROPRIATE DOSE
> Over 121 pounds (>55 kilograms)	6 mg SC daily
99 to 121 pounds (45-55 kilograms)	5 mg SC daily
77 to 98 pounds (35-44 kilograms)	4 mg SC daily

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