Prior Authorization Form

CVS-Caremark Fax Form
Anadrol/Oxandrin/Nandrolone
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **18888360730**.
Please contact CVS|Caremark at **18884143125** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Anadrol/Oxandrin/Nandrolone.

Drug Name (select from list of drugs shown)
Anadrol-50 (oxymetholone) Oxandrin (oxandrolone) Nandrolone

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

1.	Is this request for oxandrolone (Oxandrin)? [If the answer to this question is yes, may skip to question 3.]	Y	N
2.	Does the patient have the diagnosis of anemia due to deficient red-cell production, acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or the hypoplastic anemias due to the administration of myelotoxic drugs? [If the answer to this question is yes, may skip to question 11.]	Y	N
3.	Does the patient have weight loss following extensive surgery? [If the answer to this question is yes, may skip to question 11.]	Y	N
4.	Does the patient have weight loss following chronic infection? [If the answer to this question is yes, may skip to question 11.]	Y	N
5.	Does the patient have weight loss following severe trauma? [If the answer to this question is yes, may skip to question 11.]	Y	N
6.	Does the patient have cachexia of unknown cause? [If the answer to this question is yes, may skip to question 11.]	Y	N
7.	Does the patient have short stature associated with Turner Syndrome? [If the answer to this question is yes, may skip to question 11.]	Y	N
8.	Does the patient have Duchenne muscular dystrophy or Becker muscular dystrophy?	Y	N

[If the answer to this question is yes, may skip to question 11.]

9.	Does the patient have HIV-wasting syndrome?	Y	N
	[If the answer to this question is yes, may skip to question 11.]		
10.	Does the patient have growth failure due to growth hormone deficiency that has not responded adequately to treatment and requires adjunct therapy?	Y	N
11.	Does the patient have a history of liver disease?	Y	N
12.	Does the patient have a history of abnormal blood lipids (i.e. decreased HDL or increased LDL)?	Y	N
13.	Does the patient have a history of renal disease?	Y	N
14.	Does the patient have a history of coronary artery disease or atherosclerosis?	Y	N
15.	Does the patient have a history of hypercalcemia?	Y	N
16.	Is the patient a female of child bearing potential?	Y	N
	[If the answer to this question is no, may skip to question 18.]		
17.	Is the patient pregnant?	Y	N
	[If the answer to this question is yes, no further questions required.]		
18.	Does the patient have a history of prostate cancer or breast cancer?	Y	N
19.	Is the patient receiving warfarin (Coumadin) therapy?	Y	N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date