



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Oxandrolone (Medicare Prior Authorization)**

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 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Oxandrolone (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Oxandrolone

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)? | Y | N |
| [If the answer to this question is yes, then skip to question 3.] | | |
| 2. Does the patient have the diagnosis of anemia due to deficient red-cell production, e.g. acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or the hypoplastic anemias due to the administration of myelotoxic drugs? | Y | N |
| [If the answer to this question is yes, then skip to question 4.] | | |
| 3. Does the patient have HIV-wasting syndrome or HIV-related cachexia? | Y | N |
| 4. Does the patient have a history of liver disease? | Y | N |
| 5. Does the patient have a history of abnormal blood lipids (i.e. decreased HDL or increased LDL)? | Y | N |
| 6. Does the patient have a history of renal disease? | Y | N |
| 7. Does the patient have a history of coronary artery disease or atherosclerosis? | Y | N |
| 8. Does the patient have a history of hypercalcemia? | Y | N |
| 9. Is the patient a female of child bearing potential? | Y | N |
| [If the answer to this question is no, then skip to question 11.] | | |



Arkansas BlueCross BlueShield

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|--|---|---|
| 10. Is the patient pregnant?
[If the answer to this question is yes, then no further questions are required.] | Y | N |
| 11. Does the patient have a history of prostate cancer or breast cancer? | Y | N |
| 12. 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