PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Oxandrin® (oxandrolone)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy? One month or less More than 1 month
Q2. Does the member have a diagnosis of HIV/AIDS? Yes No
Q3. Does the member have a secondary diagnosis of Wasting Syndrome as defined by the CDC? (weight loss of at least 10% in the presence of diarrhea or chronic weakness, and opportunistic infections ruled out) Yes No
Q4. Does the member have a documented BCM less than 100%? Yes No
Q5. Is the member male or female? Male Female
Q6. If the member is male, does he have normal testosterone level greater than 500ng/dl? Yes No
Q7. Have you attached a nutritional consult and results of BIA? Yes No

Physician Signature **Date**

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.