

# OXANDROLONE

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

**When this form is completed, please fax to Caremark at 1--888-836-0730.**

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is this request for oxandrolone (Oxandrin)?  
[If the answer to this question is yes, then skip to question 3.]  Y  N
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?  
[If the answer to this question is yes, then skip to question 4.]  Y  N
3. Does the patient have HIV-wasting syndrome or cachexia?  Y  N

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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?  
[If the answer to this question is no, then skip to question 11.]  Y  N
10. Is the patient pregnant?  
[If the answer to this question is yes, no further question 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:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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