

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

GENERATIONS HEALTHCARE

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Anabolic Steroids (Nandrolone decanoate & Oxymetholone (Anadrol-50®): Prior Authorization Request Form: Please respond.

- Please complete the attached Anabolic Steroids (Nandrolone decanoate & Oxymetholone (Anadrol-50®) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Anabolic Steroids (Nandrolone decanoate & Oxymetholone (Anadrol-50®)

Nandrolone is only recommended for the treatment of anemia of renal insufficiency. Oxymetholone is only recommended for the treatment of anemia that is caused by deficient red cell production and acquired or congenital aplastic anemias, myelofibrosis, and/or hypoplastic anemias caused by the administration for myelotoxic drugs.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Anabolic Steroids (Nandrolone decanoate & Oxymetholone (Anadrol-50®) Criteria

- Please indicate agent requested:
 Nandrolone Oxymetholone patient)
 Carcinoma of the prostate or breast (male patient)
 Hypersensitivity to the drug or its components
 Known or suspected pregnancy
 Nephrosis or the nephrotic phase of nephritis
 Severe hepatic dysfunction (oxymetholone only)
- Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be completed.
 Renal insufficiency (nandrolone only)(ICD-9: 593.90)
 Aplastic anemia (ICD-9: 284)
 Myelofibrosis (ICD-9: 289.83),
 Drug-induced anemia
 Deficient red cell production (ICD-9: 281)
 Other _____
- Please list specialty of prescribing physician:
 Other: _____
 hematologist nephrologist
 endocrinologist oncologist
- If nandrolone is requested in the treatment of anemia of renal insufficiency, is the patient intolerant to or have contraindications to epoetin therapy?
 Yes No
- Does the patient have any of the following contraindications? (Please specify)
 Yes No
 Carcinoma of the breast with hypercalcemia (female
- Please indicate patient's hemoglobin:
 < 10 mg/dL 10- 12 mg/dL
 > 12 mg/dL

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____