Prior Authorization Form

Anadrol-50

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 Anadrol-50.

Drug Name (select from list of drugs shown)
Anadrol-50 Tablets (oxymetholone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

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

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

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for any of the following: A) Anemia due to deficient red cell production, (e.g., acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, the hypoplastic anemias due to the administration of myelotoxic drugs, Fanconi's anemia), B) Cachexia associated with acquired immunodeficiency syndrome (AIDS) (human immunodeficiency virus [HIV] wasting)?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date