



**Anadrol-50  
(Oxymetholone)**

**Prior Authorization Form  
Curascript  
Fax (888) 773-7386**

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address	City	State	ZIP
VH ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:	Diagnosis:
Sig:	Qty:
Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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1. Is the diagnosis or indication for the treatment of anemia caused by deficient red cell production?
2. What is the corrected reticulocyte count or reticulocyte index?
3. Is the diagnosis or indication for the treatment of one of the following: acquired/congenital aplastic anemia, myelofibrosis, hypoplastic anemia?
4. Does the patient have one of the following: iron, folic acid, or vitamin B12 deficiency?
5. Is the patient currently being treated for one of the following: iron, folic acid, or vitamin B12 deficiency?
6. Does the patient have a history of prostate or breast cancer?
7. Does the patient have a history of severe hepatic dysfunction or liver cell tumors?
8. Does the patient have a diagnosis of CAD or hyperlipidemia?
9. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

For Internal Use Only  
 Approved  Denied      Reviewer's Initials \_\_\_\_\_ Decision Date \_\_\_\_\_  
 Comments \_\_\_\_\_

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.