



Anadrol-50 (Oxymetholone)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address), Physician, 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

- 1. Is the diagnosis or indication for the treatment of anemia caused by deficient red cell production? (If no, continue to # 3)
2. Is the corrected reticulocyte count or reticulocyte index less than 2?
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, vitamin B12, or pyridoxine deficiency?
5. Is the patient currently being treated for one of the following: iron, folic acid, vitamin B12, or pyridoxine 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

