Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Oxandrolone - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is there documentation showing oxandrolone is prescribed as adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections or severe trauma? Please provide documentation.

☐ Yes ☐ No

Q2. Is there documentation showing oxandrolone is prescribed to offset the protein catabolism associated with prolonged administration of corticosteroids? Please provide documentation.

☐ Yes ☐ No

Q3. Is there documentation showing oxandrolone is prescribed for the relief of bone pain accompanying osteoporosis? Please provide documentation.

☐ Yes ☐ No

Q4. Does the patient have any contraindications to oxandrolone including the following: carcinoma of the prostate or the male breast, carcinoma of the breast in females with hypercalcemia, pregnancy, nephrosis, hypercalcemia?

☐ Yes ☐ No

Q5. Requested Duration:

☐ 12 Months

Q6. Additional Information:

______________________________ ______________________________

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Patient Name:	**Prescriber Name:**

Prescriber Signature Date

2023 Medicare Prior Authorization Request

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