



**OXANDROLONE (Oxandrin®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Dx Code: _____

Please answer the following questions:

For which of the following conditions is oxandrolone being prescribed? ***Please check at least one condition, and associated conditions, if requested.***

- Relief of bone pain accompanying osteoporosis
- Protein catabolism associated with chronic administration of corticosteroids
- Alcoholic hepatitis
- Severe burns
- Hereditary angioedema (C1 esterase inhibitor deficiency)
- Other (*Medical record documentation may be required*) _____
- Promotion of weight gain after weight loss – *must check at least one of the following:*
 - Following extensive surgery
 - Chronic infection(s)
 - Severe trauma
 - Patient who otherwise has failed to gain or maintain normal body weight
- HIV cachexia (unintentional weight loss of at least 10% of baseline weight, or body mass index [BMI] less than 20 kg/m², not attributable to other causes)
 - a. Has optimal antiretroviral therapy been instituted? Yes No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403