



**OXYMETHOLONE (Anadrol-50®)
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 oxymetholone being prescribed? *Please check at least one condition, and associated conditions, if requested.*

- Anemia caused by deficient red cell production and associated with one of the following conditions – *must check at least one of the following:*
 - acquired aplastic anemia
 - congenital aplastic anemia
 - anemia of chronic renal failure
 - pure red cell aplasia
 - myelofibrosis
 - Fanconi's anemia
 - hypoplastic anemia caused by the administration of myelotoxic drugs, or myelosuppression due to chemotherapy
- 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
- Hereditary angioedema (C1 esterase inhibitor deficiency)
- Other (*Medical record documentation may be required*) _____

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