OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Oxandrin® (oxandrolone) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Bone pain
- ❑ Protein catabolism
- ❑ Weight gain
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Bone pain:
Is patient's bone pain associated with osteoporosis? **❑Yes ❑No**

Protein catabolism:
Will the requested drug be used to counterbalance protein catabolism associated with chronic corticosteroid administration? **❑Yes ❑No**
Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation of a positive clinical response to therapy as evidenced by an improvement in weight gain or increase in lean body mass? **❑Yes ❑No**

Weight gain:
Will the requested medication be used as adjunctive therapy to promote weight gain? **❑Yes ❑No**
Does the patient have a diagnosis of extensive surgery, chronic infections, severe trauma, or failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons? **❑Yes ❑No**
Does the patient have a trial and failure, contraindication, or intolerance to nutritional supplements? **❑Yes ❑No**
Was a nutritional consult performed? **❑Yes ❑No**
Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation of a positive clinical response to therapy as evidenced by an improvement in weight gain or increase in lean body mass? **❑Yes ❑No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.