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Anadrol®-50 Prior Authorization Request Form

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This form may be faxed to 844-403-1029.

Men	nber Inforn	P	Provider Information (required)				
Member Name:			Provider Nan	Provider Name:			
Insurance ID#:			NPI#:	NPI#: Specialt			
Date of Birth:			Office Phone	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	ZIP:	Office Street	Office Street Address:			
Phone:		l	City:	City: State: ZIF		ZIP:	
		Medicatio	n Information	(required)			
Medication Name:			Strength:			n:	
			Directions for	Directions for Use:			
		Clinical	Information (re	equired)			
Initial Authoriza	ation:						
1. Does the patient have a diagnosis of anemia caused by deficient red				Il production? ☐ Yes ☐ No		☐ Yes ☐ No	
			indication to multiple standard therapies for osuppressants, blood transfusions, etc.? ☐ Yes ☐ N				
	replace other su xine deficiency, a	•	nsfusion, correction of iron, folic acid, vitamin steroids)?		☐ Yes ☐ No		
Reauthorization	າ:					•	
1. Is there documentation of a positive clinical response to Anadrol-50 therapy as evidenced by an improvement in anemia (e.g., increased hemoglobin, increased reticulocyte count, reduction/elimin for need of blood transfusions)?						□ Yes □ No	
Information on this	s form is accurat	e as of this date.					
Prescriber's Sig	gnature:		Date:				
Are there any other of this review?	comments, diagnos	ses, symptoms, medicatio	ns tried or failed, and/or	r any other information	on the physician	feels is important to	
For n	nore information abo	nied unless all required ir out the prior authorization pr to 1 a.m. Eastern, and Satu	ocess, please contact us				

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