



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE- ANABOLIC STEROIDS

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

1. Product: _____ Strength and Dose: _____

2. Please indicate patient's diagnosis:

- anemia caused by renal insufficiency (**nandrolone** only is approvable)
- anemia caused by deficient red blood cell production (**oxymetholone** only), please list type of anemia:

Type of anemia: _____

- bone pain caused by osteoporosis (**oxandrolone** only)
- protein catabolism associated with corticosteroid use (**oxandrolone** only)
- need for weight gain (**oxandrolone** only)

Specify need for weight gain: _____

- other diagnosis: _____
Note: If other diagnosis is used, please attach a study with efficacy data supporting this request

3. Does the patient have any of the following: Known or suspected carcinoma of the prostate or breast in men; carcinoma of the breast in women with hypercalcemia or nephrosis or the nephrotic phase of nephritis? Yes No

4. ONLY IF OXANDROLONE (if not, skip to #3). Does the member have hypercalcemia? (Skip to #5) Yes No

5. ONLY IF OXYMETHOLONE. Does the member have severe hepatic dysfunction? Yes No

6. Is the patient pregnant? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

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QUESTIONS PLEASE CALL:
877-526-9906