



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

OXANDROLONE

Coverage Criteria / Required Medical Information

All FDA approved indications not otherwise excluded from Part D

Coverage Duration: 6 months

Exclusion Criteria

Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

OXANDROLONE	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments	
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Physicians Signature: _____

Fax Form to 1-866-481-3704