Maryland AIDS Drug Assistance Program

Oxandrolone (Oxandrin) Prior Authorization Fax Form

FAX Completed Form to First Health Services Corporation 1-800-932-3921
Questions call First Health Services 1-800-932-3918

Client Name__________________________________ MADAP ID 9 4

Instructions
In order for a MADAP client to receive oxandrolone (Oxandrin), the client’s MADAP certification must meet the medical criteria listed on this form. The authorized prescriber must complete and submit this form for authorization. Clients must be diagnosed with HIV-related wasting syndrome as evidenced by a 10% loss in total body weight in less than four months and a BMI < 18.5. Male clients must have failed a clinical trial with both testosterone and nandrolone for HIV-related wasting syndrome.

Clinician Certified Medical History and Current Status

1. What is the patient’s sex? □ Female  □ Male

2. Is the patient a candidate for alternative treatment with testosterone or nandrolone? □ Yes  □ No
   (A trial with each agent is required)
   a.) Dates of prior treatment with testosterone: Start date ________ End date _________
      Treatment (check one): □ Was Successful □ Failed
      Reason for failure______________________________________________________________
   b.) Dates of prior treatment with nandrolone: Start date ________ End date _________
      Treatment (check one): □ Was Successful □ Failed
      Reason for failure______________________________________________________________

3. Patient demonstrates the following clinical signs of wasting?
   a) Patient has involuntary weight loss of more than 10% of total body weight in less than four months;
      □ Yes  □ No
   Weight (report at least 2 months):
   Weight 1 ________ Date __________________
   Weight 2 ________ Date __________________
   Weight 3 ________ Date __________________
   Weight 4 ________ Date __________________
   b) and, BMI < 18.5 (Normal BMI = 18.5 to 24.9)
      □ Yes  □ No
      Patient Height = ________________
      Patient’s BMI = ________________
      BMI = [wt (lbs.)/ht^2 (inches)] x 703

Prescriber Information (please complete legibly)
Name: ________________________________ DEA # ________________________________
Address: ___________________________________________________________________
Office Phone: __________________ Fax: __________________
Signature: ___________________________ Date: __________________

Revised 4/15/2005