



20720

Maryland AIDS Drug Assistance Program

Oxandrolone (Oxandrin) Prior Authorization

Request Date

Request date input boxes

Patient's MADAP ID Number

PATIENT INFORMATION

Patient's Date of Birth

Patient's MADAP ID Number input boxes

Patient's Date of Birth input boxes

Patient's Full Name

Patient's Full Name input boxes

Prescriber's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name input boxes

Prescriber Street Address

Prescriber Street Address input boxes

City

State

Zip Code

City input boxes

State input boxes

Zip Code input boxes

Prescriber Phone:

Prescriber Fax:

Prescriber Phone input boxes

Prescriber Fax input boxes

DEA#

DEA# input boxes

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 an involuntary weight loss of more than 10% total body weight in less than four months and a BMI < 18.5 and is not a candidate for alternative treatment with testosterone or nandrolone. 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?
2. Is the patient a candidate for alternative treatment with testosterone or nandrolone?

(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;
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)

Patient Height =
Patient's BMI =

BMI = [wt (lbs.)/ht2 (inches)] x 703

Date

Date input boxes

Signature of Prescriber

FAX TO: Maryland AIDS Drug Assistance Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

Hours: Monday - Friday 8:30 am- 4:30 pm EST

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