



Prior Authorization Department
Phone: 1-866-235-1793
Fax: 1-866-391-2929

DRUG PRIOR AUTHORIZATION REQUEST CONFIDENTIAL PATIENT INFORMATION MEDICARE B vs. D

Top portion and medication request information to be completed by physician requesting prior authorization

URGENT REQUEST (check here) ____

(MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Catamaran clinical pharmacists reserve the right to refuse to expedite a prior authorization request if the member's health condition does not meet the definition above. If you believe there is an urgency, please explain the reason for the urgency in the section provided at the bottom of page 2.)

Prescriber Information

Last Name:

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DEA/NPI:

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Phone:

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First Name:

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Specialty:

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Fax:

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Member Information

Last Name:

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Member ID Number:

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First Name:

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DOB:

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Medication Information:

Drug Name, Strength, Dosage Form:

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Diagnosis:

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Quantity and Dosing:

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Duration:

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To assist us in determining coverage under Part D or Part B, please answer any applicable questions below:

MEDICATION REQUEST – TPN agents

1. Does the patient have permanent dysfunction of digestive tract?

Y	N
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MEDICATION REQUEST – Immunosuppressants

1. Was the member's transplant covered by Medicare?

Y	N
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MEDICATION REQUEST – Hepatitis B Vaccine		
1. Does any of the following apply to the patient?	Y	N
a. Patient is at moderate risk for acquiring hepatitis B: <ul style="list-style-type: none"> i. Patient is part of the staff in institutions for the mentally challenged ii. Patient is a health care worker who has frequent contact with blood or blood derived body fluids during routine work 		
b. Patient is at high risk for acquiring hepatitis B: <ul style="list-style-type: none"> i. Patient has end-stage renal disease (ESRD) ii. Patient has hemophilia and patient has received Factor VIII or IX concentrates iii. Patient is a client of institutions for individuals for the mentally challenged iv. Patient resides in the same household as a hepatitis B virus carrier v. Patient is a homosexual male vi. Patient is an illicit injectable drug abuser 		

MEDICATION REQUEST – Tetanus or Rabies Vaccine		
1. Is the patient using for prophylaxis?	Y	N

MEDICATION REQUEST – ESRD (End-Stage Renal Disease) Medications		
1. Does the patient have a diagnosis of end-stage renal disease (ESRD)?	Y	N
2. Is the patient on dialysis?	Y	N

MEDICATION REQUEST – Oral Anti-emetics		
1. Does the patient have a diagnosis of cancer?	Y	N
2. Is the medication being used as a full replacement for IV antiemetic within 48 hours of cancer treatment?	Y	N

MEDICATION REQUEST – IV Infusion		
1. Is the medication being administered with an infusion pump?	Y	N

Comments (If urgent request as indicated on Page 1, please explain further in this section):

Information given on this form is accurate as of this date.

Prescriber or Authorized Signature:

Date: _____