

**Catamaran Prior Authorization Department****Phone: 866-235-3062****Fax: 866-391-7222****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 and Strength:

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Diagnosis:

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Quantity and Dosing:

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Duration:

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**Quantity Limit Exception
Prior Authorization Criteria****You must answer ALL of the following questions that apply to patient**

1. What is the patient's diagnosis?

Please document: _____

2. Is the requested medication being used for an FDA approved diagnosis?

Y

N

3. Is the patient unable to achieve desired results with the recommended FDA approved dosing regimen?

Y

N

Please document regimen previously tried and failed: _____

4. Is there clinical rationale supporting use of the medication beyond the maximum FDA approved dose?

Y

N

Prescriber must describe and submit supporting literature.

Comments: _____

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

Prescriber or Authorized Signature_____
Date



Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).