

**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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Sitavig Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient

You must answer ALL of the following questions that apply to patient		
1. Does the patient have a diagnosis of recurrent herpes labialis?	Y	N
2. Is the patient an immunocompetent adult?	Y	N
3. Has the patient received treatment and been compliant for a minimum of 60 days with famciclovir without an adequate response?	Y	N
4. Has the patient had a previous intolerance to treatment with famciclovir?	Y	N
5. Has the patient received treatment and been compliant for a minimum of 60 days with valacyclovir without an adequate response?	Y	N
6. Has the patient had a previous intolerance to treatment with valacyclovir?	Y	N

Comments: _____

*Information given on this form is accurate as of this date.*_____
Prescriber or Authorized Signature_____
Date_____
Authorized Medical Staff – Name/Title



Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

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).