

**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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Horizant Prior Authorization Criteria

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

1. Has the patient experienced an inadequate treatment response or intolerance to generic gabapentin?	Y	N
2. Has the patient experienced an inadequate treatment response to generic pramipexole or ropinirole?	Y	N
3. Has the patient experienced an intolerance or contraindication to generic pramipexole or ropinirole?	Y	N

Comments:

*Information given on this form is accurate as of this date.*_____
Prescriber or Authorized Signature_____
Date_____
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.



Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

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).