



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:

Diagnosis:

Quantity and Dosing:

Duration:

Topamax (topiramate) Prior Authorization Criteria

Please complete all applicable questions

1. Please document ICD-9 code: _____		
2. Is the patient currently being treated with Topamax (within the past 60 days)?	Y	N
3. Has the patient tried and failed or was intolerant to the generic topiramate?	Y	N
4. Does the patient have a diagnosis of epilepsy?	Y	N
5. Is the member an inappropriate candidate for generic topiramate?	Y	N
Please provide documentation why: _____		

Comments: _____
Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date

Authorized Medical Staff – Name/Title



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Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 800-626-0072.

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).