

**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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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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## Absorica Medical Exception Criteria

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

1. Does the patient have a diagnosis of severe recalcitrant nodular acne?	Y	N
2. Has the patient tried and had an inadequate response to at least 12 weeks of a generic isotretinoin product (such as Amnesteem, Claravis, etc.)?	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).