

**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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**Flector and Pennsaid  
Prior Authorization Criteria****You must answer ALL of the following questions that apply to patient**

1. Does the patient require NSAID treatment for pain relief in one area or joint in the body?	Y	N
2. Does the patient have a history of asthma, urticaria or other allergic type reactions after taking aspirin or other NSAIDs?	Y	N
3. Has the patient demonstrated an inadequate treatment response to at least two prescription NSAIDs or salicylates, with one of them being diclofenac? <b>If Yes, please stop</b>	Y	N
4. Has the patient demonstrated an intolerance to at least two prescription NSAIDs or salicylates, one of them being diclofenac? <b>If Yes, please stop</b>	Y	N
5. Has the patient demonstrated an adverse drug event to at least two prescription NSAIDs or salicylates, one of them being diclofenac?	Y	N



**Catamaran Prior Authorization Department**

**Phone: 866-235-3062**

**Fax: 866-391-7222**

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.**

**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).**