



**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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**Edarbi, Edarbyclor, Teveten, Teveten HCT  
Step Therapy Prior Authorization Criteria**

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

1. Has treatment with a generic ARB been ineffective for the patient? **(Please Circle)**

- Losartan (Cozaar, Hyzaar)
- Valsartan (Diovan, Diovan HCT)
- Irbesartan (Avapro, Avalide)
- Candesartan (Atacand, Atacand HCT)
- Telmisartan (Micardis, Micardis HCT)

Y

N

2. Has treatment with Benicar/Benicar HCT (olmesartan/olmesartan HCT) been ineffective for the patient?

Y

N

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

\_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date**



**Catamaran Prior Authorization Department**

**Phone: 866-235-3062**

**Fax: 866-391-7222**

**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).**