



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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Subutex (buprenorphine) and Suboxone (buprenorphine/naloxone) Prior Authorization Criteria

Initial Therapy

Please complete all applicable questions

1. What is the patient's age?

2. What is the patient's diagnosis? Please document diagnosis and ICD-9 code:

3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Subutex (buprenorphine)?

Y	N
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4. What is the prescriber's registration number?

Please document: _____

5. What additional treatment programs is the patient participating in? **(Please circle)**

- Self-help groups
- Counseling
- Provide ongoing care
- Vocational training
- Other: _____

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6. Is the patient pregnant?

Y

N

Renewal Therapy**Please complete all applicable questions**

1. What is the patient's age?

2. What is the patient's diagnosis? Please document diagnosis and ICD-9 code:

3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Subutex (buprenorphine)?

Y

N

4. What is the prescriber's registration number?

Please document: _____

5. What additional treatment programs is the patient participating in? **(Please circle)**

- Self-help groups
- Counseling
- Provide ongoing care
- Vocational training
- Other: _____

6. Is the patient pregnant?

Y

N

7. Is the patient receiving any other opioids?

Y

N

8. Is the prescriber evaluating for the both of following?

Y

N

- Random urine drug screens
- Assessment of the patient's progress (e.g., relapse, progress/accomplishment of treatment goals)

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 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).**