catamaran™

Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Cymbalta (duloxetine HCL) Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
Major Depressive Disorder (MDD), Depressive Disorder, or Dysthymia		
1) Has the patient been treated with Cymbalta in the last 60 days?	Y	N
2) Has the patient demonstrated an inadequate treatment response or have a confirmed adverse event to two generic antidepressants, one of which is an SSRI?	Y	N

Diabetic peripheral neuropathy		
1) Has the patient tried any of the following medications or had an intolerance or adverse drug event to them. If yes, please circle medication below. • Carbamazepine • Tricyclic antidepressants • Gabapentin • Trazodone • Lyrica	Y	N

Generalized Anxiety Disorder		
1) Has the patient tried any of the following medications or had an intolerance or adverse event to	Y	N

them. If yes please circle medication below. • Benzodiazepines • Venlafaxine (immediate release or extended release products) • Escitalopram, paroxetine, or sertraline		

Fibromyalgia		
1) Does the patient have widespread pain (on the left and right side of the body and above and below the waist) present for at least 3 months?	Y	N
2) Does the patient have axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) present for at least 3 months?	Y	N
3) Does the patient have at least 11 of 18 positive (painful) specific bilateral tender point sites after digital palpitation with an approximate force of 4kg? Please circle all sites that apply. • Occiput • Low cervical • Trapezius • Supraspinatus • Second rib • Lateral epicondyle • Gluteal • Greater trochanter • Knee	Y	N
4) Has the patient tried any of the following medication or had an intolerance or adverse drug event to them. If yes, please circle medication below. • Cyclobenzaprine • Tricyclic antidepressants • Fluoxetine • Lyrica • Savella	Y	N

Musculoskeletal Pain		
1) Is the patient participating in a physical activity program or graded exercise program to improve function (e.g., exercise, occupational, physical therapy)?	Y	N
2) Has the patient tried and had an inadequate response to at least TWO drugs from the following options (at least a 30 day trial)? If yes, please circle medications below. • Tramadol • NSAIDs (e.g., diclofenac, etodolac, ibuprofen, meloxicam, nabumetone, salsalate) • Opioids (e.g., codeine, hydrocodone, morphine, oxycodone)	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.

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).