

**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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**Restasis Prior Authorization Criteria****Initial Therapy****You must answer ALL of the following questions**

1. Is the member at least 16 years of age or older?	Y	N
2. Does the patient have an active ocular infection?	Y	N
3. Does the member have a diagnosis of keratoconjunctivitis sicca or chronic dry eyes?	Y	N
4. Do the records document that the patient has had a trial and inadequate response to punctal plugs?	Y	N
5. Do the records document that the patient has had an inadequate treatment response to 2 OTC ocular lubricants used in combination with an artificial tears agent?	Y	N

**Renewal Therapy****You must answer ALL of the following questions**

1. Has the patient experienced an improvement since initiating therapy with Restasis?	Y	N
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Comments: 

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*Information given on this form is accurate as of this date.*

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**Prescriber or Authorized Signature**

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**Date**

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**Authorized Medical Staff – Name/Title**



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**Phone: 866-235-3062**

**Fax: 866-391-7222**

**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).**