



**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:

\_\_\_\_\_

Diagnosis:

\_\_\_\_\_

Quantity and Dosing:

\_\_\_\_\_

Duration:

\_\_\_\_\_

**Diclegis  
Medical Exception Criteria**

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

1. Does the patient have a diagnosis of nausea and vomiting of pregnancy?	Y	N
2. Has the patient tried and had an inadequate response to a 30-day trial of over-the-counter doxylamine AND pyridoxine (Vitamin B6)?	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.**



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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).