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:

Flovent Diskus, Flovent HFA, and Pulmicort
Step Therapy Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Has the patient received treatment and been compliant for a minimum of 60 days with Asmanex (mometasone furoate) without an adequate response?	Y	N
2. Has the patient had an intolerance to treatment with Asmanex?	Y	N
3. Has the patient received treatment and been compliant for a minimum of 60 days with Qvar (beclomethasone dipropionate) without an adequate response?	Y	N
4. Has the patient had an intolerance to treatment with Qvar?.	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).