



# 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:

\_\_\_\_\_

## Fluoxetine 60mg, Luvox CR, Paxil Suspension, Pexeva, Sarafem, Viibryd, Fetzima, & Pristiq Step Therapy Prior Authorization Criteria

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

1. Is the patient currently being treated with the requested non-preferred brand antidepressant agent within the past 60 days?	Y	N
2. Has the patient tried and had an inadequate response to TWO of the following generic SSRIs or SNRIs? <b>(Please Circle)</b> <ul style="list-style-type: none"> <li>Citalopram</li> <li>escitalopram</li> <li>Fluoxetine (excluding Fluoxetine 60 mg)</li> <li>Fluvuoxamine</li> <li>Paroxetine or paroxetine CR</li> <li>Sertraline</li> <li>Venlafaxine or venlafaxine ER</li> <li>Other generic: _____</li> </ul>	Y	N
3. Does the patient have an intolerance or adverse event to two generic SSRIs or SNRIs listed above?	Y	N

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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).**