

**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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**Lamictal
Prior Authorization Criteria****You must answer ALL of the following questions that apply to patient**

1. Is the patient currently being treated with Lamictal (within the past 60 days)?	Y	N
2. Has the patient tried and failed or was intolerant to the generic lamotrigine?	Y	N
3. Does the patient have a diagnosis of epilepsy?	Y	N
4. Is the member an inappropriate candidate for generic lamotrigine?	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.



Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

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).