



**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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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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**DIFICID (fidaxomicin) Prior Authorization Criteria**

**Please complete all applicable questions**

1. Please document ICD-9 code: _____		
2. Has the patient demonstrated an inadequate treatment response to vancomycin hydrochloride after a trial of at least 14 days?	Y	N
3. Has the patient experienced an intolerance to, an adverse event with, or has a documented contraindication to vancomycin hydrochloride that would prohibit a trial of at least 14 days?	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 800-626-0072.

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).



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