



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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Sprix Nasal Spray (ketorolac tromethamine)
Prior Authorization Criteria

Please complete all applicable questions

1. What is the patient's diagnosis? Please document diagnosis and ICD-9 code:

2. What is the anticipated duration of treatment with Sprix Nasal Spray?

3. Is the patient able to swallow oral medications?

4. Has the patient experienced an inadequate treatment response or intolerance to an oral generic ketorolac product?

Please document date of trial and intolerance, if applicable: _____

Comments: _____

Information given on this form is accurate as of this date.



Catamaran Prior Authorization Department

Phone: 866-235-3062

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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).