



Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone <input type="text"/>	First Name <input type="text"/> Specialty: <input type="text"/> Fax <input type="text"/>
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Member Information

Last Name: <input type="text"/> Member ID Number <input type="text"/>	First Name <input type="text"/> DOB: <input type="text"/>
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Medication Information:

Drug Name and Strength: <input type="text"/> Diagnosis: <input type="text"/>	Quantity and Dosing: <input type="text"/> Duration: <input type="text"/>
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**Fentanyl Patch, hydromorphone ER, Methadone tabs, Methadone concentrate, Methadone oral susp, MS contin, Avinza, Kadian, Oxycontin, oxymorphone SR, Opana ER, & Nucynta Quantity Limit
Prior Authorization Criteria**

You must answer ALL of the following questions that apply to patient		
1. Is the opioid medication being used for a diagnosis of cancer pain?	Y	N
2. Does the patient require long term treatment with opioids for pain management?	Y	N
3. Is there an active treatment plan that includes, but is not limited to, a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief?	Y	N
4. Has there been an informed consent document signed by the patient and an addiction risk assessment performed?	Y	N
5. Is there a written/signed agreement between the prescriber and the patient addressing issues of prescription management, diversion, and the use of other substances?	Y	N
6. Have a list of prescribers allowed to prescribe opioids and a designated pharmacy to fill opioid prescriptions been agreed upon by the prescriber and the patient?	Y	N
7. Has the patient tried and experienced an inadequate response to a short-acting opioid within the previous 60 days?	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).