



**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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## Oral Contraceptives Prior Authorization Criteria

**You must answer ALL of the following questions**

1. What is the patient's diagnosis? **(Please circle)**

- Premenstrual dysphoric disorder
- Acne
- Menopause
- Prophylaxis for postmenopausal osteoporosis
- Endometriosis
- Heavy bleeding
- Pain/cramping
- Birth control
- Other: \_\_\_\_\_

2. Does the member have moderate to severe abnormal vasomotor function?

Y N

Comments: \_\_\_\_\_

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

\_\_\_\_\_  
Prescriber or Authorized Signature

\_\_\_\_\_  
Date



**Catamaran Prior Authorization Department**

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**Fax: 866-391-7222**

**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).**