



**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:

\_\_\_\_\_

Diagnosis:

\_\_\_\_\_

Quantity and Dosing:

\_\_\_\_\_

Duration:

\_\_\_\_\_

**Medical Exception  
Prior Authorization Criteria**

**You must answer ALL of the following questions that apply to patient**

1. What is the patient's diagnosis?

Please document: \_\_\_\_\_  
 \_\_\_\_\_

2. Has the patient tried and failed other medications for this diagnosis?

Please document ALL products and corresponding information:

Medication	Dates Tried	Reason for Failure
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Y	N
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*Please note: chart notes may be requested or prescription claims history may be used to verify prior alternative therapy*



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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).**