

**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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**Tekturna, Tekturna HCT
Prior Authorization Criteria****You must answer ALL of the following questions that apply to patient**

1. Did the patient try and fail two angiotensin-converting enzyme inhibitors (ACE-I) or combination products?

Y

N

Examples of ACE-I include: captopril, enalapril, lisinopril, and ramipril.

2. Did the patient try and fail two angiotensin II receptor blockers (ARBs) or combination products?

Y

N

Examples of ARBs include: losartan, candesartan, valsartan, Irbesartan.

3. Did the patient try and fail one ACE-I/ACE-I combination product AND one ARB/ARB combination product?

Y

N

Please see above for examples.

Comments:

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

Prescriber or Authorized Signature

Date



Catamaran Prior Authorization Department

Phone: 866-235-3062

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 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).