catamaran™

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

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Zubsolv (buprenorphine and naloxone)
Medical Exception Criteria
Initial Therapy

You must answer ALL of the following questions that apply to patient		
1. What is the patient's age? **(Please Circle)** • 16 years or older • Less than 16 years		
2. What is the member's diagnosis? **(Please Circle)** • Opioid dependence • Other _____		
3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Zubsolv?	Y	N
4. What is the prescriber's registration number? Please document: _____		

5. What additional treatment programs is the patient participating in? **(Please Circle)** A. Self-help groups B. Counseling C. Provide ongoing care D. Vocational training E. Other _____ F. None		
6. Is the patient pregnant?	Y	N
7. Has the patient had a trial/failure or intolerance to both the buprenorphine/naloxone tablet (Suboxone) AND buprenorphine/naloxone film (Suboxone Film) formulation?	Y	N

Zubsolv (buprenorphine and naloxone)
Prior Authorization Criteria
Renewal Therapy

You must answer ALL of the following questions that apply to patient		
1. What is the patient's age? **(Please Circle)** • 16 years or older • Less than 16 years		
2. What is the member's diagnosis? **(Please Circle)** • Opioid dependence • Other _____		
3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Zubsolv?	Y	N
4. What is the prescriber's registration number? Please document: _____		
5. What additional treatment programs is the patient participating in? **(Please Circle)** A. Self-help groups B. Counseling C. Provide ongoing care D. Vocational training E. Other _____ F. None		
6. Is the patient pregnant?	Y	N
7. Is the patient receiving any other opioids?	Y	N
8. Is the prescriber evaluating for the both of following? A. Random urine drug screens B. Assessment of the patient's progress (e.g., relapse, progress/accomplishment of treatment goals)	Y	N

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).