

**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:

Diagnosis:

Quantity and Dosing:

Duration:

Onfi (clobazam) Prior Authorization Criteria**Please complete all applicable questions**

1. Is the patient currently receiving another anticonvulsant therapy? Y N

2. What is the member's diagnosis? Please document diagnosis and ICD-9 code:

3. What types of seizures associated with Lennox-Gastaut Syndrome is the member having? 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 800-626-0072.**



Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

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).