Catamaran Prior Authorization Department
Phone: 800-626-0072
Fax: 866-511-2202

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: ____________

Quantity Limit Exception

You must answer ALL of the following questions		
1. Please document diagnosis and ICD-9 code:______________________________________		
2. Has the patient demonstrated an inability to achieve desired results with the recommended FDA approved dosing regimen? If yes, please document previously tried and failed failed regimen:______________________ ____	Y	N
3. Is there clinical rationale supporting use of the medication beyond the maximum FDA approved dose? If Yes, please document rationale:______________________________________ ____	Y	N

Comments: ____

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

______________________________________ ______________________

Prescriber or Authorized Signature **Date**

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Authorized Medical Staff – Name/Title

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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).