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:

Tekturna (aliskiren)/Tekturna HCT (aliskiren/hydrochlorothiazide) Prior Authorization Criteria

You must answer ALL of the following questions		
1. Please document ICD-9 code: _____		
2. Did the patient try and fail two angiotensin-converting enzyme inhibitors (ACE-I) or combination products? Please list: _____	Y	N
3. Did the patient try and fail two angiotensin II receptor blockers (ARBs) or combination products? Please list: _____	Y	N
4. Did the patient try and fail one ACE-I/ACE-I combination product AND one ARB/ARB combination product? Please list: _____	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).