



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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Flector and Pennsaid (diclofenac topical) Prior Authorization Criteria

You must answer ALL of the following questions

1. Please document ICD-9 code: _____		
2. Does the patient require NSAID treatment for pain relief in only one area or joint in the body?	Y	N
3. Has the patient demonstrated an inadequate treatment response to, intolerance to, or had a confirmed adverse event to at least TWO prescription NSAIDs or salicylates?	Y	N
4. Is one of the NSAIDS an oral diclofenac?	Y	N
5. Is the patient able to tolerate oral therapy?	Y	N
6. Does the patient have a history of asthma, urticaria or other allergic type reactions after taking aspirin or other NSAIDs?	Y	N

Comments: _____

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

Prescriber or Authorized Signature

Date

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 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).