



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:

DIFICID (fidaxomicin) Prior Authorization Criteria

You must answer ALL of the following questions

1. Please document ICD-9 code: _____		
2. Has the patient demonstrated an inadequate treatment response to vancomycin hydrochloride after a trial of at least 14 days?	Y	N
3. Has the patient experienced an intolerance to, an adverse event with, or has a documented contraindication to vancomycin hydrochloride that would prohibit a trial of at least 14 days?	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).



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