



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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**Invokana
Prior Authorization Criteria**

You must answer ALL of the following questions that apply to patient

1. Does the patient have one or more of the following contraindications or exclusions to the use of Invokana? (Please Circle)	Y	N
A. Severe renal impairment (estimated glomerular filtration rate [eGFR] less than 45 mL/min/1.73 m2)		
B. End stage renal disease (ESRD)		
C. Currently requiring dialysis		
D. Diabetic ketoacidosis		
E. Pediatric patient (under the age of 18 years)		
2. Does the patient have a diagnosis of type 2 diabetes mellitus and has had an inadequate response to diet and exercise alone?	Y	N
3. Did the patient try and have an inadequate response or intolerance to therapy with metformin?	Y	N
4. Did the patient try and have an inadequate response or intolerance to therapy with one additional anti-diabetic agent?	Y	N
<i>Examples include a sulfonylurea, TZD, DPP4 inhibitor, GLP-1 agonist, etc.</i>		

Comments: _____

**Catamaran Prior Authorization Department****Phone: 866-235-3062****Fax: 866-391-7222**

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).