

**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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**Fulyzaq
Prior Authorization Criteria****You must answer ALL of the following questions that apply to patient**1. What is the member's age? **(Please circle)**

- 18 years of age or older
- Less than 18 years

2. Does the patient require symptomatic relief of noninfectious diarrhea?

Y N

3. Has non-infectious diarrhea (such as cryptosporidiosis, c. difficile, etc.) been ruled out?

Y N

4. Does the patient have HIV/AIDS?

Y N

5. Is the patient receiving anti-retroviral therapy?

Y N

6. Has the prescriber considered changing the anti-retroviral regimen in order to improve the patient's diarrhea?

Y N

7. Has the patient tried and failed BOTH standard anti-diarrheal medications: loperamide and atropine/phenoxybate?

Y N



Catamaran Prior Authorization Department

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Fax: 866-391-7222

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).