

**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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**Bisphosphonate (Fosamax Plus D, Bonisto, Actonel, Atelvia, Skelid) Step Therapy Prior Authorization Criteria****Initial Therapy****You must answer ALL of the following questions**

1. Please document ICD-9 code: \_\_\_\_\_

2. Has the patient had a trial and inadequate response to a generic bisphosphonate (ie. alendronate)?

Y

N

3. Does the patient have an intolerance to a generic bisphosphonate?

Y

N

Please document: \_\_\_\_\_

Comments: \_\_\_\_\_

*Information given on this form is accurate as of this date.*\_\_\_\_\_  
Prescriber or Authorized Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Authorized Medical Staff – Name/Title



**Catamaran Prior Authorization Department**

**Phone: 866-235-3062**

**Fax: 866-391-7222**

**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).**