



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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Celebrex (celecoxib) Prior Authorization Criteria

You must answer ALL of the following questions

1. Please document ICD-9 code:_____		
2. Will the patient continue on more than one drug from the same drug class or more than one drug on the duplicate therapy drug list?	Y	N
3. Has the patient had an inadequate treatment response to at least two prescription non-steroidal anti-inflammatory drugs (NSAIDs) or salicylates? Please document product names and dates of trial:_____	Y	N
4. Has the patient had an intolerance or a confirmed adverse drug event with at least two prescription non-steroidal anti-inflammatory drugs (NSAIDs) or salicylates? Please document product names and adverse event/intolerance:_____	Y	N
5. Does the member have a diagnosis of Familial Adenomatous Polyposis (FAP)?	Y	N

Comments: _____

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

Prescriber or Authorized Signature

Date



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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).