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

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Suboxone (buprenorphine/naloxone)
Prior Authorization Criteria

Initial Therapy You must answer ALL of the following questions		
1. What is the patient's age?		
2. What is the patient's diagnosis? Please document diagnosis and ICD-9 code:		
3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone (buprenorphine/naloxone)?	Y	N
4. What is the prescriber's registration number? Please document: _____		
5. What additional treatment programs is the patient participating in? **(Please circle)** • Self-help groups • Counseling • Provide ongoing care • Vocational training • Other: _____		

6. Is the patient pregnant?	Y	N

Renewal Therapy **You must answer ALL of the following questions**		
1. What is the patient's age? _____ _____		
2. What is the patient's diagnosis? Please document diagnosis and ICD-9 code: _____ _____		
3. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone (buprenorphine/naloxone)?	Y	N
4. What is the prescriber's registration number? Please document: _____		
5. What additional treatment programs is the patient participating in? **(Please circle)** • Self-help groups • Counseling • Provide ongoing care • Vocational training • Other: _____		
6. Is the patient pregnant?	Y	N
7. Is the patient receiving any other opioids?	Y	N
8. Is the prescriber evaluating for the both of following? • Random urine drug screens • Assessment of the patient's progress (e.g., relapse, progress/accomplishment of treatment goals)	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).