



1650 Spring Gate Lane
 Las Vegas, NV 89134
 Tel: 888-869-4600

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION FORM

COMPLETE AND FAX TO CATAMARAN™ AT 888-852-1832

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-9	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			
IgE: _____			
ESR: _____ CRP: _____ # Joints: _____ %BSA: _____			
Height: _____ Weight: _____ BMI: _____			
HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____			
Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____			
Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____			
Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____			
HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	
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