Date _____

restat
a Catamaran company

Caterpillar Prescription Drug Benefit

PRIOR AUTH CRITERIA- OPANA IR (oxymorphone)

M.D. Last Name: _____ ***M.D. First Name:***_____

Physician Phone: _____***Physician Fax:*** _____

Patient _____ ***ID#***_____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. **Has the patient tried any other oral opioid within the past 30 days? (check one)**

_____ **No**

_____ **Yes (please list)** _____

_____

_____

Physician Specialty (REQUIRED)_____

Physician Signature (REQUIRED)_____

Physician Comments _____

_____

Send or Fax completed form to:
877-722-8329

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906

Once a coverage determination has been made, you will be notified by fax at the physician's fax number provided above.

DOCTOR'S NOTE: Caterpillar Prior Authorization forms are located at ***www.CatHealthBenefits.com*** on the "For Providers" tab. Print a new form for each request as forms are updated periodically.

DATE 1/1/14