GEORGIA DEPARTMENT OF COMMUNITY HEALTH

catamaran™

Georgia Watch Form

Fee-for-Service Medicaid &
PeachCare for Kids

Prior Authorization
Claims Processing
Phone: (866) 525-5827
Fax: (888) 491-9742
P.O. Box 3214
Lisle, IL 60532-8214

FAX TO: 888-491-9742

Today's Date _____

Note: All of the following requests for information must be answered completely, correctly, and legibly, otherwise the authorization process will be delayed.

First, Middle, Last
Member Full Name _____

Member ID# _____ Member DOB ____/____/____

Medication/Strength Requested _____ Dosage Form _____ Quantity _____

Diagnosis _____ Directions _____

Generic products tried? *(Circle one)* NO or YES *If yes, list the names of the manufacturers of generic products tried.*

1. _____ 2. _____ 3. _____

What was the patient's response to each generic product? *(A response description MUST be given.)*

Product Name	Response
1.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	
2.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	
3.	☐ Subtherapeutic Response ☐ Allergy ☐ Side Effect ☐ Other
Response description:	

Please print legibly
Physician's Name _____

Physician's Signature _____

Required
NPI Number _____

Physician Address _____

Physician Phone _____ Physician Fax _____

Medical Office Contact _____ Signature _____

Any additional information pertaining to this drug request should be included and attached to this form.