

**Complete Patient and Physician information (PLEASE PRINT)**

STEP 1	Patient Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone # :
	Member DOB:	Fax #:
		Tax ID or NPI Number:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

**Please attach all relevant medical records and test results.**

STEP 2	Diagnosis	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Other (please state): _____ _____ _____
	Physician Specialty	<input type="checkbox"/> Neurologist	<input type="checkbox"/> Other (please state): _____
	<i>* There is no physician specialty requirement for Medicare Part D members</i>		
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):		
	Please attach a copy of the prescription or provide ALL of the information below: Apomorphine (Apokyn <sup>®</sup> ) Strength _____ Sig _____ Qty _____ Refills _____		
<b>Incomplete forms will not be processed.</b>			

**I certify that the above is correct and accurate to the best of my knowledge (please sign and date).**

STEP 3	_____	_____
	Prescriber Signature	Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
 970-248-5034**

Name of Person filling out form: \_\_\_\_\_

Pharmacy Technician initials \_\_\_\_\_ Date Initiated \_\_\_\_\_

**Confidentiality Notice:**

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