Caverject® or Edex® (alprostadil) Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member 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:

Diagnosis	☐ Patient being treated for erectile dysfunction resulting from surgical or radiation treatment of prostate cancer
	☐ Other, please specify:
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):
	Please attach a copy of the prescription or provide ALL of the information below: ☐ Caverject ® ☐ Edex ® (alprostadil) Strength _____ Sig _____ Qty _____ Refills _____
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**

STEP 3

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

_____ _____
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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03/10/10