

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:

STEP
2

<p>Transdermal Fentanyl Patch When prescribed with dosing frequency other than 1 patch every 3 days, an explanation of dosing rationale or medical necessity is required.</p>	
Clinical rationale:	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):
	Please attach a copy of the prescription or provide ALL of the information below: Duragesic [®] (fentanyl transdermal patch) Strength _____ Sig _____ Qty _____
	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
Prior authorization form must be filled out completely before requests will be processed.

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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