

**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><b>Transdermal Fentanyl Patch</b>          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 <sup>®</sup> (fentanyl transdermal patch) Strength _____ Sig _____ Qty _____
	Please attach all relevant medical records and test results. <b>Incomplete forms will not be processed.</b>

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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