

Complete Patient and Physician information (PLEASE PRINT)

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2	Physician Specialty	<input type="checkbox"/> Oncologist	<input type="checkbox"/> Other (please state): _____
	Clinical Documentation	<input type="checkbox"/> Aprepitant is being used with a moderate to highly emetic chemotherapy regimen With what regimen? _____	
		<input type="checkbox"/> Other (please state): _____	
	Supporting Documentation	<input type="checkbox"/> Aprepitant is being used in combination with another antiemetic. Please state which antiemetics: _____	
Diagnosis: ICD-9 Code #/ Description (required):			
Please attach a copy of the prescription or provide ALL of the information below: Emend [®] (aprepitant)			
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**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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