

**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:**

Diagnosis	<input type="checkbox"/> Patient being treated for erectile dysfunction resulting from surgical or radiation treatment of prostate cancer
	<input type="checkbox"/> Other, please specify: _____
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):
	Please attach a copy of the prescription or provide ALL of the information below: <input type="checkbox"/> Caverject® <input type="checkbox"/> Edex® (alprostadil) Strength _____ Sig _____ Qty _____ Refills _____
	Please attach all relevant medical records and test results. <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**

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

**Confidentiality Notice:**

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