

**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

Diagnosis	<input type="checkbox"/> Hormone receptor positive metastatic breast cancer	<input type="checkbox"/> Other (please state):
Clinical Consideration:	<input type="checkbox"/> Patient has tried and failed tamoxifen	<input type="checkbox"/> Other (please state):
Physician Specialty	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other (please state):
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Faslodex <sup>®</sup> (fulvestrant) Strength _____ Sig _____ Qty _____ Refills _____	
	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

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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