

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

<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 (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**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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