

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"/> Congestive Heart Failure	<input type="checkbox"/> Other (please state):
	<input type="checkbox"/> Hypertension	
Clinical Consideration	<input type="checkbox"/> Previous trial of spironolactone	
	<input type="checkbox"/> Spironolactone therapy ineffective	
	<input type="checkbox"/> Documented intolerance to spironolactone therapy	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Inspira [®] (eplerenone)	
	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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