

**Complete Patient and Physician information (PLEASE PRINT)**

STEP  
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

STEP  
2

Diagnosis	<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Hypertension	<input type="checkbox"/> Other (please state): _____
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 / J Code (required): _____	
	Please attach a copy of the prescription or provide ALL of the information below: Inspira <sup>®</sup> (eplerenone) 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**

Name of Person filling out form: \_\_\_\_\_

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

**Confidentiality Notice:**

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 03/11/10