

**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"/> 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 / 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:**

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