

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 Number:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis	<input type="checkbox"/> Prophylaxis of deep vein thrombosis in patients undergoing elective hip replacement surgery <input type="checkbox"/> Other (please state): _____
Clinical Consideration	<input type="checkbox"/> Patient has <i>never</i> been treated with an antihirudin agent (e.g. desirudin, lepirudin, bivalirudin). -Due to antibody formation, patients can not be re-treated. <input type="checkbox"/> Patient has a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Patient has received initial treatment of Iprivask pre-surgery
Physician Specialty	Diagnosis made by: <input type="checkbox"/> Orthopedic Surgeon <input type="checkbox"/> Other (please state): _____
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required): _____
	Please attach a copy of the prescription or provide ALL of the information below: Iprivask [®] (desirudin) Strength _____ Sig _____ Qty _____ Refills _____
	<p style="text-align: center;"><i>*Please attach all relevant medical records and test results*</i></p> <p style="text-align: center;">We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.</p>

STEP
3

I certify that the above is correct and accurate to the best of my knowledge and that the form is complete. (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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