

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"/> Non Small Cell Lung Cancer <input type="checkbox"/> Other (please state):
		Indicate if the cancer progressed despite prior regimens with docetaxel and platinum based chemotherapy [Platinol (cisplatin), Paraplatin (carboplatin), Eloxatin (oxaliplatin),] <div style="text-align: center;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div>
STEP 2	Physician Specialty	<input type="checkbox"/> Oncologist <input type="checkbox"/> Other (please state):
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required): Please attach a copy of the prescription or provide ALL of the information below: Iressa [®] (geftinib) Strength _____ Sig _____ Qty _____ Refills _____
		Please attach all relevant medical records and test results. Incomplete forms will not be processed.

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3 _____ Date _____
 Prescriber Signature

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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