Ixempra® (ixabepilone)
Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

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: ____

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ Metastatic or locally advanced Breast CA ☐ Used in combination with capecitabine	☐ Other (please state):
	☐ Cancer is resistant or refractory to anthracycline AND taxane therapy ☐ Cancer is refractory to capecitabine *-If Ixempra is being used as monotherapy, CA must be refractory to capecitabine* ***Please provide documentation of previous treatment with anthracycline, taxane and capecitabine(if applicable)**	
Physician Specialty	☐ Oncologist	☐ 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: Ixempra® (ixabepilone) 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

Name of Person filling out form: ______________________________________

Pharmacy Technician initials ______ Date Initiated ____________________

Confidentiality Notice:

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