

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"/> Pulmonary arterial hypertension (PAH) with NYHA Group II-IV symptoms— either primary or secondary etiology	<input type="checkbox"/> Other (please state): _____ _____
Physician Specialty	<input type="checkbox"/> Pulmonology at an approved Pulmonary Hypertension Clinic	<input type="checkbox"/> Other (please state): _____
Care management (CM nurse should monitor patient to optimize therapy)	<input type="checkbox"/> Care Management Nurse has been notified regarding follow up Nurse's name (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: Remodulin [®] (treprostinil)	
	Infusion site _____ Strength _____ Sig _____ Qty _____ Refills _____	
<p><i>*Please attach all relevant medical records and test results*</i></p> <p>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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