

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"/> Emesis prevention in patients receiving moderate or highly emetogenic IV chemotherapy	<input type="checkbox"/> Other (please state): _____
Physician Specialty	Diagnosis made by: <input type="checkbox"/> Oncologist <input type="checkbox"/> Other (please state): _____	
Clinical Consideration	Please list the antineoplastic agent(s) with moderate to high emetogenic potential and the number of cycles the patient will be receiving: Antineoplastic agent(s): _____ Number of cycles: _____	
	Please attest to the following: There exists a reasonable possibility that other serotonin (5-HT3) antagonist formulations (ie. generically available oral granisetron) will not sufficiently control the patient's symptoms of nausea and vomiting: <input type="checkbox"/> Yes <input type="checkbox"/> No	
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: Sancuso [®] (granisetron patch) Strength _____ Sig _____ Qty _____ Refills _____	
	Please attach all relevant medical records and test results 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.	

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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