

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"/> Patient must have diagnosis of depression.	<input type="checkbox"/> Other (please state): _____
Clinical Consideration	<input type="checkbox"/> Patient has tried and failed a previous antidepressant Which medication (please state): _____	
	If the patient has received nefazodone in the months preceding coverage with RMHP then the prescription should automatically be approved for continuity of care as directed by CMS for MEDICARE or evaluated on a case by case basis for PRIVATE PAY . PATIENTS NAÏVE TO NEFAZODONE WILL NOT BE CONSIDERED.	
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required): _____	
	Please attach a copy of the prescription or provide ALL of the information below: Serzone [®] (nefazodone) 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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