

**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:**

**Please attach all relevant medical records and test results.**

STEP  
2

Diagnosis	<input type="checkbox"/> Newly diagnosed Chronic Phase Ph+CML <input type="checkbox"/> Previously diagnosed Chronic Phase Ph+CML <i>(resistance or intolerance to prior therapy)</i> <input type="checkbox"/> Accelerated Phase Ph+CML <i>(resistance or intolerance to prior therapy)</i> <input type="checkbox"/> Lymphoid Blast Phase Ph+ CML <i>(resistance or intolerance to prior therapy)</i> <input type="checkbox"/> Myeloid Blast Phase Ph+CML <i>(resistance or intolerance to prior therapy)</i> <input type="checkbox"/> Ph+ ALL <i>(resistance or intolerance to prior therapy)</i>	<input type="checkbox"/> Other (please state): _____ _____ _____ _____ _____ _____
Clinical Consideration	<b>For all indications EXCEPT newly diagnosed Chronic Phase Ph+CML</b> <input type="checkbox"/> Patient has attempted therapy with Gleevec (imatinib) and is intolerant or refractory. <i>(Documentation required)</i> <input type="checkbox"/> Adult Patient <input type="checkbox"/> Diagnosis made by oncologist	
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: Sprycel <sup>®</sup> (dasatinib)	
	Strength _____ Sig _____ Qty _____ Refills _____	
<b>We will not process incomplete forms.</b> <b>If we do not receive the completed form &amp; all relevant medical records &amp; test results within 10 calendar days of this request, it will be denied.</b>		

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:**

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 01/10/12