

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"/> Chronic Phase CML <input type="checkbox"/> Philadelphia chromosome + <input type="checkbox"/> Newly diagnosed OR <input type="checkbox"/> Resistant or Intolerant to prior therapy <input type="checkbox"/> Accelerated Phase CML <input type="checkbox"/> Philadelphia chromosome +	Other (please state): _____ _____ _____ _____
	Clinical Consideration	<input type="checkbox"/> Patient has attempted therapy with Gleevec (imatinib) and is intolerant or refractory. <i>-Patient must be refractory or intolerant to Gleevec for approval of Tasigna, UNLESS patient is newly diagnosed (Ph+CML) in chronic phase</i> <input type="checkbox"/> Adult Patient	
	Physician Specialty	<input type="checkbox"/> Oncologist	<input type="checkbox"/> Other: _____
	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: Tasigna [®] (nilotinib) Strength _____ Sig _____ Qty _____ Refills _____	

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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