

**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"/> NYHA Class III or IV, W.H.O Group I, Pulmonary Arterial Hypertension	<input type="checkbox"/> Other (please state): _____ _____ _____
Physician Specialty	<input type="checkbox"/> Pulmonology	<input type="checkbox"/> Other (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: Ventavis <sup>®</sup> (iloprost trometamol) Strength _____ Sig _____ Qty _____ Refills _____	
	<p align="center"><i>*Please attach all relevant medical records and test results*</i></p> <p align="center"><b>We will not process incomplete forms.</b></p> <p align="center"><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></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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