

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"/> Advanced Renal Cell Carcinoma with clear cell histology	<input type="checkbox"/> Other (please state): _____ _____ _____
	Physician Specialty	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other (please state): _____
	Clinical Consideration	<input type="checkbox"/> Diagnosis of locally advance or metastatic renal cell carcinoma	
	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: Votrient® (pazopanib) Strength _____ Sig _____ Qty _____ Refills _____ <i>*Please attach all relevant medical records and test results*</i> 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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