BlueCross BlueShield Nebraska

AMPYRA™ PREAUTHORIZATION
PHYSICIAN FAX FORM

The following documentation is REQUIRED for preauthorization. Incomplete forms will be returned for additional information.
For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at ***www.nebraskablue.com***

Patient Information

Today's Date: _____

Patient Name:	Patient DOB (mm/dd/yyyy):

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

Prescriber Name:	Specialty:	
Clinic Name and Address:		
Clinic City, State, Zip Code:	Phone Number:	Secure Fax Number:

PLEASE NOTE: If approved, a maximum of sixty 60mg tablets are authorized per 30 days.

Preauthorization Information

Initial Authorization

1. Patient's diagnosis (ICD 10 code): _____
2. Is the patient ambulatory? ☐Yes ☐No
   Results of 25-foot timed walk: _____
   Estimated EDSS Score: _____
3. Does the patient have a history of seizure disorder? ☐Yes ☐No
4. Please describe any limitations the patient has when performing activities of daily living due to slow ambulation: _____
5. Please provide any additional information that should be considered when reviewing this request: _____
6. Anticipated follow-up visit: _____

Renewal Authorization

1. Is there improvement in functional impairment in the patient's ability to complete instrumental activities of daily living due to the use of the medication? ☐Yes ☐No
   Please explain: _____
2. If performed, results of the 25-foot timed walk: _____
3. Estimated EDSS Score: _____
4. Please provide any additional information that should be considered when reviewing this request: _____

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll-Free Fax: 877-232-6726
Phone: 877-999-2374