

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):
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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

- Patient's diagnosis (ICD 10 code): _____
- Is the patient ambulatory? Yes No
 Results of 25-foot timed walk: _____
 Estimated EDSS Score: _____
- Does the patient have a history of seizure disorder? Yes No
- Please describe any limitations the patient has when performing activities of daily living due to slow ambulation: _____

- Please provide any additional information that should be considered when reviewing this request: _____

- Anticipated follow-up visit: _____

Renewal Authorization

- 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: _____

- If performed, results of the 25-foot timed walk: _____
- Estimated EDSS Score: _____
- 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

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