BlueCross BlueShield Nebraska

ATTENTION DEFICIT (HYPERACTIVITY) DISORDER (ADHD/ADD) POLICY X.86 PREAUTHORIZATION REQUEST

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient and Insurance Information

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (mm/dd/yyyy):
Patient Address:	City, State, ZIP	Member ID Number:	

Prescriber Information

Prescriber Name:	Prescriber NPI:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Clinic Phone Number:	Secure Fax Number:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description

☐ ADHD/ADD ☐ Narcolepsy ☐ Binge Eating Disorder

Medication Requested: _____	Strength: _____
Dosing Schedule: _____	Quantity per Month: _____

1. Is the patient currently being treated with the requested medication?..... ☐ Yes ☐ No

   If yes, is the patient at risk if they change therapy?..... ☐ Yes ☐ No

2. Previous therapies, if applicable: _____

3. Additional clinical information: _____

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

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