BlueCross BlueShield Nebraska

AUTOIMMUNE BIOLOGIC THERAPY POLICY X.42, X.43, X.44 PREAUTHORIZATION REQUEST PRESCRIBER FAX FORM

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/Pharmacy. *Save time by filling out this preauthorization form 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.

Patient and Insurance Information

Today's Date: _____

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

Diagnosis for request for biologic use:

- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Uveitis
- ☐ Crohn's Disease
- ☐ Juvenile Idiopathic Arthritis
- ☐ Hidradenitis Suppurativa
- ☐ Psoriasis
- ☐ Non-radiographic Axial Spondyloarthritis
- ☐ Psoriatic Arthritis
- ☐ Giant Cell Arteritis
- ☐ Ulcerative Colitis
- ☐ Other: _____

Requested product:

- ☐ Humira
  - ☐ Adalimumab biosimilar: _____
- ☐ Remicade
  - ☐ Infliximab biosimilar: _____
- ☐ Rituxan
  - ☐ Rituximab biosimilar: _____
- ☐ Stelara
  - ☐ Ustekinumab biosimilar: _____
- ☐ Tyenne
  - ☐ Actemra
- ☐ Cimzia
- ☐ Cosentyx
- ☐ Enbrel
- ☐ Entyvio
- ☐ Ilaris
- ☐ Kevzara
- ☐ Kineret
- ☐ Olumiant
- ☐ Orencia
- ☐ Otezla
- ☐ Rinvoq
- ☐ Siliq
- ☐ Simponi
- ☐ Simponi Aria
- ☐ Skyrizi
- ☐ Taltz
- ☐ Tremfya
- ☐ Xeljanz or Xeljanz XR
- ☐ Zeposia

Requested Dose: _____ Patient weight: _____ Date: _____

INITIAL AUTHORIZATION

1. Is the patient currently treated with the requested medication?..... ☐ Yes ☐ No
   If yes, is the patient at risk if they change therapy? Please explain: _____
2. Previously tried medications for the stated diagnosis: _____

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RENEWAL AUTHORIZATION

1. Have the patient's symptoms improved since initiation of biologic therapy?..... ☐ Yes ☐ No
2. Has the patient improved physical function since the initiation of biologic therapy?..... ☐ Yes ☐ No
3. Has therapy inhibited structural damage progression since the initiation of biologic therapy?..... ☐ Yes ☐ No

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

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