

Bowel Preparation Medications for Preventive Colonoscopy Screening

The following documentation is **REQUIRED** for review. 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

Today's Date: _____

PATIENT INFORMATION

First Name:	Last Name:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
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INSURANCE INFORMATION

BCBSNE ID Number:

PHYSICIANS/CLINIC INFORMATION

Prescriber Name:	Physician UPIN:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:		
City, State, Zip:			Phone Number:	Secure Fax Number:

REQUIRED INFORMATION

Medication Requested:
Medication Dose Requested: _____
Diagnosis (ICD-10 Dx Code): _____
Is the colonoscopy being conducted in accordance with USPSTF colorectal cancer screening? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when was their most recent screening?
Provide clinical evidence and documentation for the use of this medication as a preventative tool in accordance with the recommendations of the U.S. Preventative Services Task Force:
Please list all clinical information documenting why the current zero dollar bowel prep medications are not medically appropriate:

Please fax additional information with this form if necessary and pertinent to this review.

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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