BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

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:

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? ☐ YES ☐ 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