

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 [Visit MedicalPolicy.NebraskaBlue.com](http://VisitMedicalPolicy.NebraskaBlue.com).*

What is the priority level of this request? <input type="checkbox"/> Standard review - Completed within 15 calendar days of receipt. <input type="checkbox"/> 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 INFORMATION Today's Date: _____

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:

PREAUTHORIZATION INFORMATION

Medication Requested: _____
Medication Dose Requested: _____
Diagnosis (ICD-10 Dx Code): _____
Is the patient currently being treated with the requested medication: <input type="checkbox"/> YES <input type="checkbox"/> NO
Please list all medications the patient has previously tried and failed for treatment of this diagnosis as well as dates used: _____ _____
Please list all clinical information documenting why the current zero dollar contraceptive medications are not medically appropriate: _____ _____

Please attach any additional information that should be considered with this request

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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