BlueCross BlueShield Nebraska

Contraceptive Out-of-Pocket Reduction Physician 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. *Start saving time by filling out this preauthorization electronically at* Visit 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 INFORMATION

Today's Date: _____

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:

PREAUTHORIZATION INFORMATION

Medication Requested: _____

Medication Dose Requested: _____

Diagnosis (ICD-10 Dx Code): _____

Is the patient currently being treated with the requested medication: ☐ YES ☐ 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