

The following documentation is **REQUIRED** for the penalty waiver review process.  
Incomplete forms will be returned for additional information. For formulary information, please visit website at [NebraskaBlue.com](http://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 Member ID Number:
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**Physician/Clinic Information**

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

**Please answer the following questions.**

**For the waiver to apply, all of the following questions must be met.**

**Medication Requested:** \_\_\_\_\_

**Medication Dose Requested:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

1. Has the prescriber requested that the brand name be dispensed instead of an FDA-approved generic equivalent?

**AND**

2. Has the patient tried an FDA-approved generic equivalent to the requested brand-name medication?

**AND**

3. Has an FDA MedWatch form 3500 been completed by the prescriber and submitted to the U.S. Department of Health and Human Services?

**AND**

4. Is the submitted copy of the FDA MedWatch form 3500 attached to this request? (Please attach copy)

**Have all of the above requirements been met?.....**  Yes  No

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  
PO Box 3248  
Omaha, NE 68180-0001  
**Toll Free Fax:** 877-232-6726  
**Phone:** 877-999-2374

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