BlueCross BlueShield Nebraska

Dispense as Written (DAW)
Prescriber Indicated - Penalty Waiver Form

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***.

Today's Date: _____

Patient Information

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

Insurance Information

BCBSNE Member ID Number:

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