BlueCross BlueShield Nebraska

Entresto Preauthorization Physician Fax Form

The following documentation is REQUIRED for preauthorization. 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***

Patient Information

Today's Date:

Patient Name:	DOB (mm/dd/yyyy):

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

Prescriber Name:	Specialty:	
Clinic Name and Address:		
Clinic City, State, Zip Code:	Phone Number:	Secure Fax Number:

PLEASE ATTACH ANY ADDITIONAL CLINICAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Preauthorization Information

Patient Diagnosis - ICD 10 code plus description: _____

Medication Requested: _____ Strength: _____

Dosing Schedule: _____ Quantity per Month: _____

1. Does the patient have NYHA Class II - IV heart failure?..... ☐Yes ☐No
2. What is the baseline or current left ventricular ejection fraction: _____
3. Is the patient currently on a beta blocker?..... ☐Yes ☐No

   If no, does the patient have an intolerance or contraindication to a beta blocker?..... ☐Yes ☐No

   If yes, which beta blocker is the patient currently on?: _____
4. Will the patient be taking Entresto in combination with an ACE inhibitor or aliskiren?..... ☐Yes ☐No
5. Does the patient have a history of angioedema related to previous ACE inhibitor or ARB therapy?.... ☐Yes ☐No
6. Is the patient pregnant?..... ☐Yes ☐No
7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____ Date: _____

_____ Date: _____

_____ Date: _____

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

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Phone: 877-999-2374