

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): _____
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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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. What is the baseline or current left ventricular ejection fraction: _____	
3. Is the patient currently on a beta blocker?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, does the patient have an intolerance or contraindication to a beta blocker?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the patient have a history of angioedema related to previous ACE inhibitor or ARB therapy?.... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is the patient pregnant?..... <input type="checkbox"/> Yes <input type="checkbox"/> 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
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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