

**GENERAL MEDICATION  
 PREAUTHORIZATION  
 PHYSICAL 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](http://NebraskaBlue.com). *Start saving time by filling out this preauthorization form electronically at [MedicalPolicy.NebraskaBlue.com](http://MedicalPolicy.NebraskaBlue.com) to begin using this free service.*

|   |
|---|
| <b>What is the priority level of this request?</b><br><br><input type="checkbox"/> Standard review - Completed within 15 calendar days of receipt.<br><br><input type="checkbox"/> 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: \_\_\_\_\_

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

**INSURANCE INFORMATION**

|                 |
|-----------------|
| BCBS 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): \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

1. Is the patient currently being treated with the requested medication:     YES     NO

2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis:

\_\_\_\_\_

\_\_\_\_\_

3. Please list clinical information that should be included in this review:

\_\_\_\_\_

\_\_\_\_\_

**Please fax additional information with this form if necessary and pertinent to this review.**

**Please fax or mail this form to:**

Prime Therapeutics  
 Pharmacy Department - UM  
 PO Box 3248  
 Omaha, NE 68180-0001

**Toll Free Fax:** 877.232.6726  
**Phone:** 877.999.2374

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