BlueCross BlueShield Nebraska

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION: PRE-EXPOSURE PROPHYLAXIS (PREP) MEDICATIONS
PHYSICIAN FAX FORM

The following documentation is REQUIRED for review to determine whether services can be provided without member cost-share. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska (BCBSNE) website at ***www.NebraskaBlue.com***

Today's Date: _____

Patient Information

Patient Name:	Patient 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:

Required Information

1. Medication requested: ☐ Descovy
2. Does the patient have a diagnosis of HIV? ☐ Yes ☐ No
3. Is the patient at high risk of contracting HIV? ☐ Yes ☐ No
4. Does the patient have a contraindication to or is unable to tolerate emtricitabine-tenofovir disoprozil fumarate (Truvada)? ..... ☐ Yes ☐ No

If yes, please explain: _____

_____

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