



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

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