

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. *Start saving time by filling out this preauthorization electronically at [Visit MedicalPolicy.NebraskaBlue.com](http://VisitMedicalPolicy.NebraskaBlue.com).*

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

Today's Date: _____

Patient Information

Patient Name:	Patient 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:

Required Information

1. Medication requested: <input type="checkbox"/> Descovy <input type="checkbox"/> Truvada	
2. Does the patient have a diagnosis of HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is the patient at high risk of contracting HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is the patient unable to tolerate or do they have a contraindication to emtricitabine-tenofovir disoproxil fumarate (generic Truvada)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain: _____	

Please fax or mail this form to:
 Blue Cross and Blue Shield of Nebraska
 Pharmacy Department - UM
 PO Box 3248
 Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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