BlueCross BlueShield Nebraska

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION: PRE-EXPOSURE PROPHYLAXIS (PREP) MEDICATIONS
PHYSICIAN 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. *Start saving time by filling out this preauthorization electronically at*
Visit MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ 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):

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 ☐Truvada
2. Does the patient have a diagnosis of HIV? ☐Yes ☐No
3. Is the patient at high risk of contracting HIV? ☐Yes ☐No
4. Is the patient unable to tolerate or do they have a contraindication to emtricitabine-tenofovir disoprozil fumarate (generic Truvada)?..... ☐Yes ☐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