



HMG CO-A REDUCTASE INHIBITOR (STATIN) PREAUTHORIZATION PHYSICIAN FAX FORM

The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at www.nebraskablue.com

Patient Information

Today's Date: _____

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

Insurance Information

| |
|------------------|
| BCBSNE ID Number |
|------------------|

Physician/Clinical Information

| | | | |
|------------------------|-----------------|-----------------|--------------------|
| Prescriber Name: | Physician NPI#: | Speciality: | Contact Name: |
| Clinic Name: | | Clinic Address: | |
| City, State, Zip Code: | | Phone Number: | Secure Fax Number: |

Preauthorization Information

| | |
|--|-----------|
| Medication Requested: | Strength: |
| <p>1. Is the patient currently being treated with this medication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Patient's diagnosis to be treated with the requested medication: _____</p> <p>3. Other diagnoses and/or prior history pertinent to this request: _____</p> <p>4. Patient's baseline (pretreatment) fasting lipid panel:</p> <p style="padding-left: 20px;">Total Cholesterol _____ Triglycerides _____ HDL _____ LDL _____</p> <p>5. Patient's goal LDL _____ AND goal % LDL reduction _____</p> <p>6. Please list all reasons for selecting the requested medication and strength over alternatives (e.g. contraindications, allergies or history of adverse drug reactions): _____</p> <p>_____</p> <p>_____</p> <p>7. Please list any other medications the patient is currently taking for treatment of this diagnosis: _____</p> <p>_____</p> <p>8. Please list all statins that the patient has previously tried and failed for the treatment of this diagnosis as well as the duration. (Please specify if the patient has tried brand-name products or generic products): _____</p> <p>_____</p> <p>_____</p> | |

Please attach any additional information that should be considered with this request

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

CONFIDENTIALITY NOTE: The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by phone, and return the original message to us at the address to the left via the US Postal Service.