BlueCross BlueShield Nebraska

# HMG CO-A REDUCTASE INHIBITOR (STATIN)
## Policy X.24
## PREAUTHORIZATION
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 form electronically at* 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.

## 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: |
|---|---|
| | |

1. Is the patient currently being treated with this medication?..... ☐ Yes ☐ No
2. Patient's diagnosis to be treated with the requested medication: _____
3. Other diagnoses and/or prior history pertinent to this request: _____
4. Patient's baseline (pretreatment) fasting lipid panel:

   Total Cholesterol _____ Triglycerides _____ HDL _____ LDL _____
5. Patient's goal LDL _____ AND goal % LDL reduction _____
6. Please list all reasons for selecting the requested medication and strength over alternatives (e.g. contraindications, allergies or history of adverse drug reactions): _____
7. Please list any other medications the patient is currently taking for treatment of this diagnosis: _____
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): _____

**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
PO Box 3248
Omaha, NE 68180-0001

**Toll Free Fax:** 877.232.6726
**Phone:** 877.999.2374