BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

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:

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
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877.232.6726
Phone: 877.999.2374