

**HEPATITIS C TREATMENT
PREAUTHORIZATION
PHYSICIAN FAX FORM**



NEBRASKA

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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

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Telephone Number:
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INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:	Phone Number:	Secure Fax Number:		

PREAUTHORIZATION INFORMATION

<p>INITIAL AUTHORIZATION - PLEASE PROVIDE LABORATORY DOCUMENTATION FOR ALL SCORES</p> <p>1. Patient's diagnosis: <input type="checkbox"/> Chronic Hepatitis C Genotype: _____ Baseline HCV RNA: _____ IU/mL <input type="checkbox"/> Other (please provide ICD code plus description): _____</p> <p>Medication Requested: _____</p> <p>Requested duration of treatment: _____</p> <p>Child-Pugh Score: _____</p> <p>2. Does the patient have evidence consistent with cirrhosis? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Does the patient have compensated liver disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Will the patient be treated concomitantly with Pegasys or PegIntron AND ribavirin? <input type="checkbox"/> YES <input type="checkbox"/> NO If being treated with PegIntron, has the patient failed treatment with Pegasys? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, does the patient have a contraindication to Pegasys? <input type="checkbox"/> YES <input type="checkbox"/> NO Explain: _____</p> <p>5. Has the patient been previously treated for Hepatitis C? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what was the patient treated with? _____ When was the patient treated? _____ What was the patient's response to therapy? _____ Did the patient discontinue therapy due to treatment intolerance? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Anticipated Start Date: _____</p>

Please fax or mail this form to:
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 Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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