HEPATITIS C TREATMENT PREAUTHORIZATION
PHYSICIAN FAX FORM

NEBRASKA
Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

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:

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

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

INITIAL AUTHORIZATION - PLEASE PROVIDE LABORATORY DOCUMENTATION FOR ALL SCORES

1. Patient's diagnosis: ☐ Chronic Hepatitis C Genotype: _____ Baseline HCV RNA: _____ IU/mL
   ☐ Other (please provide ICD code plus description): _____
   Medication Requested: _____
   Requested duration of treatment: _____
   Child-Pugh Score: _____
2. Does the patient have evidence consistent with cirrhosis? ☐ YES ☐ NO
3. Does the patient have compensated liver disease? ☐ YES ☐ NO
4. Will the patient be treated concomitantly with Pegasys or PegIntron AND ribavirin? ☐ YES ☐ NO
   If being treated with PegIntron, has the patient failed treatment with Pegasys? ☐ YES ☐ NO
   If no, does the patient have a contraindication to Pegasys? ☐ YES ☐ NO Explain: _____
   _____
5. Has the patient been previously treated for Hepatitis C? ☐ YES ☐ 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? ☐ YES ☐ NO
6. Anticipated Start Date: _____

Please fax or mail this form to:
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