

**MULTIPLE SCLEROSIS 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](http://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**

**Medication Requested:** Aubagio Avonex Extavia Gilenya Tysabri

1. Patient's diagnosis to be treated with requested medication \_\_\_\_\_

	<u>Medication</u>	<u>Dates</u>
2. Has the patient tried at least one of the following formulary medications:	Betaseron..... <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	Copaxone..... <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	Plegridy..... <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	Rebif..... <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
	Tecfidera..... <input type="checkbox"/> YES <input type="checkbox"/> NO	_____

3. Is the patient currently being treated with disease modifier therapy?  YES  NO  
If yes, please indicate which medications and when started:  
\_\_\_\_\_

4. Does the patient have contraindications to Betaseron, Copaxone, Plegridy, Rebif, or Tecfidera?.....  YES  NO  
If yes, please describe which agent(s) and what the contraindications are \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are there other clinical considerations that would require the use of the requested medication? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please include any additional clinical information that should be considered for this review: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please fax or mail this form to:**  
Blue Cross and Blue Shield of Nebraska  
Pharmacy Department - UM  
1919 Aksarben Drive • P.O. Box 3248  
Omaha, NE 68180-0001  
**Toll Free Fax: 877-232-6726**  
**Phone: 877-999-2374**

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