BlueCross BlueShield Nebraska

MULTIPLE SCLEROSIS THERAPY
POLICY X.31
PREAUTHORIZATION REQUEST
PRESCRIBER 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.

Today's Date: ________________

## Patient and Insurance Information

| Patient First Name: | Patient Last Name: | Middle Initial: | Date of Birth (mm/dd/yyyy): |
|---|---|---|---|
| Patient Address: | City, State, ZIP | Member ID Number: | |

## Prescriber Information

| Prescriber Name: | Prescriber NPI: | Specialty: | Contact Name: |
|---|---|---|---|
| Clinic Name: | Clinic Address: | | |
| City, State, ZIP: | Clinic Phone Number: | Secure Fax Number: | |

## PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's diagnosis - ICD code plus description:

☐ Clinically Isolated Syndrome
☐ Relapsing Remitting Multiple Sclerosis
☐ Primary Progressive Multiple Sclerosis
☐ Active Secondary Progressive Multiple Sclerosis

Medication Requested:

| Self-administered Products: | Clinic-administered Products: | Excluded Products: |
|---|---|---|
| ☐ Ampyra | | |
| ☐ Dimethyl fumarate | ☐ Ocrevus | ☐ Extavia |
| ☐ Glatiramer Acetate | ☐ Lemtrada | |
| ☐ Aubagio | ☐ Tysabri | |
| ☐ Avonex | | |
| ☐ Betaseron | | |
| ☐ Copaxone | | |
| ☐ Gilenya | | |
| ☐ Glatopa | | |
| ☐ Mayzent | | |
| ☐ Plegridy | | |
| ☐ Rebif | | |
| ☐ Tecfidera | | |
| ☐ Vumerity | | |
| ☐ Zeposia | | |

1. Is the patient currently treated with the requested medication?................................................................. ☐ Yes ☐ No

If yes, is the patient at risk if they change therapy?...................................................................................... ☐ Yes ☐ No

2. Previous therapies and dates of use:

Therapy #1: ____________________ Therapy #2: ____________________ Therapy #3: ____________________

**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

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