BlueCross BlueShield Nebraska

ORAL FENTANYL POLICY X.13 PREAUTHORIZATION
PHYSICIAN 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 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 Information

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

1. Patient's diagnosis: _____
2. Medication and strength requested: _____ Quantity requested per day: _____
3. Is the patient being treated with the requested medication for hospice, palliative, or terminal care? ☐ Yes ☐ No
   If no, does the patient currently have a pain contract with the requesting physician (please include copy) ☐ Yes ☐ No
4. Is the patient taking concomitant opioids for persistent pain? ☐ Yes ☐ No
5. Please list all medications the patient is currently taking for pain: _____
6. Does the patient have a contraindication, intolerance, or treatment failure to other short-acting opioids or cannot take medication by other routes of administration? ☐ Yes ☐ No
   If YES, please explain: _____
7. If the patient is taking a long-acting opioid, can the dose be adjusted to help control episodes of breakthrough pain? ☐ Yes ☐ No
   If no, please explain: _____
8. Please provide any additional information that should be considered when reviewing this request:

_____

_____

_____

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
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877.232.6726
Phone: 877.999.2374