BlueCross BlueShield Nebraska

SELF - ADMINISTERED ONCOLOGY
POLICY X.124
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 electronically at* Visit MedicalPolicy.NebraskaBlue.com.

Today's Date: _____

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.

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/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI #:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Phone #:		Secure Fax #:

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

Patient's Diagnosis-ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

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. Please provide the following: Patient's Weight: _____ (kg). Patient's Height: _____ (cm).

3. Does the patient have an FDA-approved indication for treatment with the requested agent?..... ☐ Yes ☐ No

4. Does therapy with the requested agent require a specific genetic/diagnostic test for the requested indication (e.g., BRAFmutation, mutation, HER2 positive)?..... ☐ Yes ☐ No

If yes, has the patient completed the appropriate FDA approved genetic/diagnostic testing and results indicate therapy with the requested drug is appropriate?..... ☐ Yes ☐ No

5. Is the requested agent approved for use as the first line agent for the requested indication as supported by standard of care and guidelines (NCCN Compendium level of evidence or 2A)?..... ☐ Yes ☐ No

If no, has the patient tried and had an inadequate response to the first line agent(s) for the requested indication?..... ☐ Yes ☐ No

If no, does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to the first line agent(s) for the the requested indication?..... ☐ Yes ☐ No

Requests for brand name products that have a generic equivalent:

6. Has the patient tried the available generic product for the requested indication?..... ☐ Yes ☐ No

If no, does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to the generic product?.. ☐ Yes ☐ No

If yes, please explain: _____

_____

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