

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

Requested long-acting Oxycodone products: XTAMPZA ER GENERIC OXYCODONE ER OXYCONTIN

Dose requested: _____

Diagnosis for use: _____

- Has the patient tried/failed preferred product, Xtampza ER?..... Yes No
- Is the patient currently treated with the requested medication?..... Yes No
- If yes, is the patient at risk if they change therapy?..... Yes No

3. Previously tried medications: _____

4. Additional clinical information: _____

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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