BlueCross BlueShield Nebraska

MEDICATIONS FOR RISK REDUCTION OF PRIMARY BREAST CANCER IN WOMEN
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* Visit 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.

Patient Information

Today's Date: _____

Patient Name:	Patient DOB (mm/dd/yyyy):

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

Prescriber Name:	Specialty:	
Clinic Name and Address:		
Clinic City, State, ZIP:	Phone Number:	Secure Fax Number:

PLEASE NOTE: If member cost-share is removed, the length will be based on time left to provide up to a total of five years of treatment.

Required Information

1. Medication requested: ☐Tamoxifen ☐Raloxifene ☐Anastrozole ☐Exemestane ☐Letrozole
2. When did the patient start treatment with requested medication? _____
3. Patient's diagnosis (ICD 10 code): _____
4. Is the member at high risk of breast cancer? ☐Yes ☐No
   Please provide documentation from risk assessment models: _____
   _____
   _____
5. Is the patient a female 35 years of age or older? ☐Yes ☐No
6. Does the patient have a personal history of breast cancer, ductal carcinoma in situ or lobular carcinoma in situ? ☐Yes ☐No
7. Does the patient have a personal history of thromboembolic events (deep venous thrombosis, pulmonary embolus, stroke or transient ischemic attack? ☐Yes ☐No

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

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Phone: 877-999-2374