BlueCross BlueShield Nebraska

AUTOIMMUNE BIOLOGIC THERAPY
POLICY X.42, X.43, X.44
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

Diagnosis for request for biologic use:

☐ Rheumatoid Arthritis ☐ Juvenile Idiopathic Arthritis ☐ Psoriatic Arthritis
☐ Ankylosing Spondylitis ☐ Hidradenitis Suppurativa ☐ Giant Cell Arteritis
☐ Uveitis ☐ Psoriasis ☐ Ulcerative Colitis
☐ Crohn's Disease ☐ Non-radiographic Axial Spondyloarthritis
☐ Other: _____

Requested product:

☐ Humira ☐ Kevzara ☐ Enbrel ☐ Actemra
☐ Cosentyx ☐ Xeljanz or Xeljanz XR ☐ Stelara ☐ Rinvog
☐ Orencia ☐ Otezla ☐ Kineret ☐ Tremfya
☐ Olumiant ☐ Taltz ☐ Ilaris ☐ Siliq
☐ Cimzia ☐ Skyrizi ☐ Simponi or Simponi Aria ☐ Entyvio
☐ Rituxan ☐ Zeposia ☐ Remicade

Requested Dose: _____ Patient weight: _____ Date: _____

INITIAL AUTHORIZATION

1. Is the patient currently treated with the requested medication?..... ☐ Yes ☐ No
   If yes, is the patient at risk if they change therapy? Please explain: _____
2. Previously tried medications for the stated diagnosis: _____

_____

_____

_____

BlueCross BlueShield Nebraska

RENEWAL AUTHORIZATION

1. Have the patient's symptoms improved since initiation of biologic therapy? ..... ☐ Yes ☐ No
2. Has the patient improved physical function since the initiation of biologic therapy? ..... ☐ Yes ☐ No
3. Has therapy inhibited structural damage progression since the initiation of biologic therapy? ..... ☐ 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

Toll Free Fax: 877-232-6726
Phone: 877-999-2374

CONFIDENTIALITY NOTE: The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by phone, and return the original message to us at the mailing address to the left.