BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Medicare Advantage Part B Drug Request Form

Clinical Review Request for Blue Cross and Blue Shield of Nebraska Medicare Advantage Members

Attention: – Pharmacy Department

Fax: 1-855-342-9648

Note: This form is for Medicare Advantage Part B Benefit Drugs. To request authorization for drugs covered under the Medicare Part D Pharmacy Benefit, please call the Blue Cross and Blue Shield of Nebraska Clinical Pharmacy Help Desk at 855-457-1349

Date: _____

Instructions:

This form may be used by participating physicians and providers to request clinical review for drugs covered under the medical benefit for Blue Cross and Blue Shield of Nebraska. Complete this form and fax it to **1-855-342-9648** along with supporting clinical documentation. Please contact Care Management at **1-877-399-1671** for any questions.

ALL REQUESTED INFORMATION MUST BE PROVIDED FOR CONSIDERATION FOR COVERAGE.
PLEASE TYPE OR PRINT CLEARLY

Step 1:
Patient and Physician Information

Patient Information	
Name:	
DOB:	
Weight:	
Member ID:	
Fax:	

Ordering Provider Information	
Name:	
Specialty:	
NPI:	
Phone:	
Fax:	

Administering Provider/Facility Information	
Name:	
Specialty:	
NPI:	
Phone:	
Fax:	

Step 2:
Provider of Service and Treatment Information

Required for ALL requests

Treatment Start Date: _____

Diagnosis Code(s): _____ HCPCS: _____

Place of Service(Please Circle): Home Outpatient Provider Office

Step 3:
Medical Information

Drug information

Drug Name: _____ Dose: _____ Frequency: _____

Length of Treatment: _____ Diagnosis: _____

Step 4: Other Relevant History and Information	Please fax all required clinical criteria and information indicated for this medication in the document Clinical Information for Drugs Covered under the Medical Benefit That Require Medical Necessity Review.
Step 5: Contact Information	Please provide the name and telephone number (and extension, if applicable) of the person Blue Cross and Blue Shield of Nebraska should notify when a decision is made. Name: _____ Phone: _____

PLEASE FAX THE COMPLETED MEDICARE ADVANTAGE PART B BENEFIT DRUG FORM AND SUPPORTING DOCUMENTATION TO 1-855-342-9648.

TO REQUEST AUTHORIZATION FOR DRUGS COVERED UNDER THE MEDICARE PART D PHARMACY BENEFIT, PLEASE CALL 855-457-1349.