



**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 |  |
|---------------------|--|
| <b>Name:</b>        |  |
| <b>DOB:</b>         |  |
| <b>Weight:</b>      |  |
| <b>Member ID:</b>   |  |
| <b>Fax:</b>         |  |

| Ordering Provider Information |  |
|-------------------------------|--|
| <b>Name:</b>                  |  |
| <b>Specialty:</b>             |  |
| <b>NPI:</b>                   |  |
| <b>Phone:</b>                 |  |
| <b>Fax:</b>                   |  |

| Administering Provider/Facility Information |  |
|---|--|
| <b>Name:</b>                                |  |
| <b>Specialty:</b>                           |  |
| <b>NPI:</b>                                 |  |
| <b>Phone:</b>                               |  |
| <b>Fax:</b>                                 |  |

**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: \_\_\_\_\_

|  |  |
|--|--|
| <b>Step 4:</b><br>Other Relevant<br>History and<br>Information | Please fax all required clinical criteria and information indicated for this medication in the document <a href="#">Clinical Information for Drugs Covered under the Medical Benefit That Require Medical Necessity Review</a> . |
| <b>Step 5:</b><br>Contact<br>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.<br>Name: _____<br>Phone: _____                           |

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify Blue Cross and Blue Shield of Nebraska at 1-877-399-1671 immediately to arrange for the return of this document.

**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.**