



*Medicare Advantage Part B Drug Request Form
Clinical Review Request for Blue Cross and Blue Shield of Nebraska
Medicare Advantage Health Plan Members*

Attention: – Pharmacy Department
Fax: 1-855-342-9648

Date: _____

Instructions: This form may be used by participating providers to request clinical review of drugs covered under the medical benefit for Blue Cross and Blue Shield of Nebraska Medicare Advantage Health Plan. Complete this form and fax it to 1-855-342-9648 along with supporting clinical documentation. Please contact the intake team at 1-877-399-1671 with 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:	
	Member ID:	
	Ordering Provider Information	
	Name:	
	Specialty:	
	NPI:	
	Contact Name & Phone #	
	Fax:	
	Administering Provider/Facility Information	
	Name:	
	Specialty:	
	NPI:	
Phone:		
Fax:		
Step 2: Provider of Service and Treatment Information	**Required for ALL requests** Drug Information	
	Treatment Start Date: _____	Length of treatment: _____
	Diagnosis Code(s): _____	HCPCS: _____
	Drug Name: _____	Dose: _____ Frequency: _____
	Place of Service (Please Check):	Home Outpatient Provider Office
Step 3: Other Relevant History and Information	Please fax all required clinical documentation to 1-855-342-9648	

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