GENERAL MEDICATION PREAUTHORIZATION
PHYSICIAN FAX FORM

NEBRASKA

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

The following documentation is REQUIRED for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at ***www.nebraskablue.com***

Today's Date: ______________________________

PATIENT INFORMATION

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Telephone Number:

INSURANCE INFORMATION

BCBS ID Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:		Phone Number:	Secure Fax Number:	

PREAUTHORIZATION INFORMATION

Medication Requested: ____

Medication Dose Requested: ____

Diagnosis: ____

Height: ______________ **Weight:** ________________

1. Is the patient currently being treated with the requested medication: ☐ YES ☐ NO

2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis:

____

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3. Please list clinical information that should be included in this review:

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Please fax additional information with this form if necessary and pertinent to this review.

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • P.O. Box 3248
Omaha, NE 68180-0001

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

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