

**GENERAL MEDICATION
PREAUTHORIZATION
PHYSICAL 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 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.

PATIENT INFORMATION

Today's Date: _____

Patient Name (First):	Last Name:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
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INSURANCE INFORMATION

BCBS ID Number:

PHYSICIANS/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 (ICD-10 Dx Code):
Height: _____ Weight: _____
1. Is the patient currently being treated with the requested medication: <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis:
3. Please list clinical information that should be included in this review:

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

Please fax or mail this form to:

Prime Therapeutics
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877.232.6726

Phone: 877.999.2374

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