PRIME THERAPEUTICS®

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:

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: ☐ YES ☐ 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