

**AMEVIVE® / RAPTIVA® PREAUTHORIZATION
PHYSICIAN FAX FORM**



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.bcbsne.com

Today's Date: _____

PATIENT INFORMATION

Patient Name:	Patient Date of Birth (mm/dd/yyyy):
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INSURANCE INFORMATION

BCBSNE ID Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:		
Clinic Name and Address:		
Clinic City, State, Zip:	Phone #:	Secure Fax #:

PREAUTHORIZATION INFORMATION

Please answer only the questions 1 through 4 for patients who have not been treated with Amevive or Raptiva before. Questions 5 and 6 apply only to patients continuing treatment with Amevive or Raptiva.

1. Patient's diagnosis to be treated with Amevive or Raptiva _____
2. How long has the patient experienced symptoms from the diagnosis? _____
3. What is the percent surface area involvement? _____
4. What treatments have been used previously to treat the diagnosis? _____

5. If the patient has been treated previously with Amevive or Raptiva, on what date was the last dose administered?

6. If the patient has been treated previously with Amevive or Raptiva, what was the outcome of treatment? _____

REQUIRED LABORATORY VALUES Please list all available test results and dates

CD4+ lymphocyte count(s) / date tested _____ _____
Amevive or Raptiva quantity requested _____ Length of therapy requested _____
Please provide any information that should be considered when reviewing this request (e.g., contraindications to other available therapies). _____ _____ _____

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
7261 Mercy Road
Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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