

**TOPICAL ACNE AGENTS  
PREAUTHORIZATION  
PHYSICIAN FAX FORM**



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](http://www.bcbsne.com)

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

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

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

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

**PREAUTHORIZATION INFORMATION**

Medication Requested (check one)

<input type="checkbox"/> AVITA®	<input type="checkbox"/> RETIN-A®	<input type="checkbox"/> RETIN-A MICRO®	<input type="checkbox"/> DIFFERIN®
<input type="checkbox"/> TAZORAC®	<input type="checkbox"/> tretinoin	<input type="checkbox"/> TRETIN-X™	<input type="checkbox"/> ATRALIN™
			<input type="checkbox"/> ZIANA™

1. Patient's diagnosis to be treated with requested medication \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. Date of last office visit examining this diagnosis \_\_\_\_\_
3. Other diagnoses and/or prior history pertinent to this request \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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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