BlueCross BlueShield Nebraska

Formulary Exception Form
For Qualified Health Plans Only

The following documentation is REQUIRED for review. 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*.**

Patient Information

Today's Date: _____

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

Insurance Information

BCBSNE ID Number:

Physician/Clinic Information

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

Formulary Review 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:

_____

_____

_____

3. If any, please provide documentation that all formulary alternatives are contraindicated, likely to be less effective, will cause an adverse reaction or other harm that is not seen with the requested medication, or what risks are associated with changes in therapy:

_____

_____

_____

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

Toll Free Fax: 800-424-7106
Phone: 877-999-2374