NEBRASKA
DEPARTMENT OF INSURANCE

Nebraska Standard Prior Authorization Instructions for Prescription Drug Benefits/DME

Nebraska Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the insurance carrier from whom you are seeking authorization. ***Do not send this form*** *to the Nebraska Department of Insurance, the Nebraska Department of Health and Human Services, or the patient's or subscriber's employer.*

On January 1, 2026, all insurers and providers must accept the Nebraska Standard Prior Authorization Request Form for Drug Benefits or Durable Medical Equipment (DME) the plan requires prior authorization of a health care service.

Intended Use: Use this form to request prior authorization for service(s) from an insurance carrier. Some insurance carriers may offer an **online version of this form** on their website or portal, allowing to complete and submit the request electronically.

Submitters should check the insurance carrier's website to understand all data needed, including clinical data, for that insurance carrier. Failure to do so could delay a decision.

By completing and submitting this form, you are attesting that all information is complete and accurate.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request a referral to an out of network physician, facility or other health care provider; or 7) request prior authorization for provider administered medication billed by the provider.

Additional Information and Instructions:

Section I - Submission: An insurance carrier may have already entered this information on the copy of this form posted on its website.

Section II - General Information:
Urgent reviews: Request an urgent review for a patient if waiting seven days for the authorization could (a) seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or (b) subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Section IV - Provider Information:

- If the insurance carrier's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VII - Clinical Documentation:

- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, drugs previously attempted, etc.), required by insurance carrier.

Note: *Some insurance carriers may require more information, which must be reflected on their website, in order to process your request. If additional information is required, it will be outlined on their website. Please check their website before submitting your request.*

Ambetter Health
Complete and Fax to:
DME: 833-588-2738
Buy & Bill Drugs: 833-893-1481
Prescription Drugs: 800-977-4170
OR Complete Electronically at https://www.covermymeds.com/main/prior-authorization-forms/
OR Mail requests to: Pharmacy Services PA Dept, 5 River Park Place East, Suite 210, Fresno, CA 93720

NEBRASKA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS/DME

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SECTION I - SUBMISSION

Insurance Carrier Name: Ambetter Health	Phone: 1-833-890-0329	Fax:	Date:

SECTION II - GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment Previous Auth #:		
☐ Continuation of Care	Carrier Name:	Auth #:
(Please attach approved PA details for Continuation of Care in Section VII)		

SECTION III - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Subscriber Name (if different):	Member ID:	Group #:	

SECTION IV - PROVIDER INFORMATION

Requesting Provider or Facility			
Name:			
NPI #:	Specialty:		
Phone:	Fax:		
Address: Street:			
City:	State:	ZIP:	
Requesting Provider/Facility Email Address:			

SECTION V - PATIENT/DRUG/PRODUCT INFORMATION

Patient Clinical Data		
Diagnosis	Diagnosis Code	ICD Version

Drug Information

Medication Name	Quantity	Strength	Frequency	Days Supply	Route of Administration	Approximate Duration

☐ Drug Administered in Clinical Setting ☐ Drug Dispensed to Patient by Pharmacy

Previous Medications Failed

Drug Name	Strength	Frequency	Dates Started/Stopped or Duration	Reason for Failure

Product/DME

Device Name	Expected Duration	HCPCS Code

SECTION VI - DATE INFORMATION

Date of Request:	Expected service begin date:	Expected service end date:

SECTION VII - CLINICAL DOCUMENTATION (SEE INSTRUCTIONS ON PAGE 1, SECTION VII)

Contact Name:	Phone: