Geisinger
Health Plan

Prior Authorization Request Form

Please fax completed form to 570-300-2122, 570-271-5610, or 855-214-1500. Medical documentation may be requested.

IF REQUEST IS MEDICALLY URGENT, PLEASE REQUEST AN EXPEDITED REVIEW.

For questions please call GHP pharmacy department at 800-988-4861, Monday – Friday, 8:00 a.m. – 5:00 p.m.

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain, or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations) (Applicable to Gold products only)
- Biotech or other specialty drugs for which drug-specific forms are required. Please refer to http://www.thehealthplan.com/providers_us/provider.cfm for the applicable order form. (Applicable to all products)

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Member ID#:		NPI# (if available):	
Address:		Address:	
City:	State:	City:	State:
Home Phone:	Zip:	Office Phone #:	Office Fax #: / Zip:

Sex (circle): M F	DOB:	Contact Person:

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
No. of Refills:	Directions for Use:	
Prescriber's Signature:	Date:	

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)
Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
Specify below: Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage
Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

Request for formulary tier exception, applicable to Medicare Beneficiaries with Part D coverage Only
Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other: ____ Explain below

REQUIRED EXPLANATION: ____

____

____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]. BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Instructions for Completing the Form

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.
NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

Geisinger Health Plan
Pharmacy Department 32-45
100 North Academy Avenue
Danville, PA 17822
Fax: 570-300-2122, 570-271-5610, or 1-855-214-1500

Clinical Management Procedures*

The Health Plan's[1] Pharmacy Department maintains a process by which Health Care Providers can:

• Request precertification for medication(s) designated in the Formulary by an asterisk (*) as requiring such

• Request a Formulary exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in the Health Plan's then current drug Formulary

Formulary exception requests will be evaluated and a determination of coverage made utilizing all the following criteria:

1. Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract)

2. Utilization of the requested agent for a clinically proven treatment indication or diagnosis

3. Therapeutic failure, intolerance or contraindication to use of Formulary agent and/or agents designated as therapeutically equivalent

4. Appropriateness of the non-Formulary agent compared with available Formulary agents, including but not limited to:
a. Safety

b. Efficacy

c. Therapeutic advantage as demonstrated by head to head clinical trials

d. Meets Health Plan criteria for drug or drug class Formulary exception

* Please refer to the Health Plan's Provider Guide and Formularies for further information.

Please note that the Formulary Exception / Prior Authorization process is an independent process and is not in conjunction with the Specialty Pharmacy Drug Program.

[1] Geisinger Health Plan and Geisinger Indemnity Insurance Company shall be collectively referred to as "Health Plan."

For Health Plan internal use only:
Date received______________ Date reviewed_______________ Request approved: Y / N / NA
HPPNM17

P:\DANVILLE3\GHP\GHP_Provnet\PUB\PCOC\Forms\form_excep_1008.doc