Geisinger Health Plan

Long-acting (Intramuscular) Atypical Antipsychotic Request Form

Instructions: All areas MUST BE COMPLETED to process the request. This form must be submitted with relevant clinical information for a specialty pharmacy vendor drug that requires prior authorization (please fax clinical information and form to the appropriate UM fax number 570-271-5534 and Pharmacy 570-271-5610). If the request is approved, this form will serve as the prescription. If the requested drug does not require prior authorization, fax the completed form (prescription) to the pharmacy department. For questions regarding the form, please contact Geisinger Health Plan pharmacy department at 800-988-4861.

Patient information (print legibly)

Patient name:_____ D.O.B.:_____ Weight:_____

Address: _____ City:_____ State: _____ Zip:_____

Home phone: _____ Daytime phone: _____

Diagnosis: _____ ICD-9 code: _____ Member ID #:_____

Physician information (print legibly)

Physician name: _____ State license #:_____ NPI #:_____

Office address: _____ City: _____ State: _____ Zip:_____

DEA#:_____ Office contact:_____

Office phone #:_____ Office fax #:_____

Shipping Information

Medication will be shipped to provider's office.

*Use of the specialty vendor is not mandatory if the provider intends to buy and bill.

Prescription information □ **New prescription** □ **Refill prescription** **(Required) Date needed**: _____

Please select one:

□ Abilify Maintena □ Invega Sustenna □ Invega Trinza □ Risperdal Consta □ Zyprexa Relprevv

Strength	Directions for use	Quantity	Number of refills

Signature (Signature is required, no stamps. Prescriber certifies this is his/her full and usual signature.)

Physician Signature – dispense as written: _____ Date:_____

Physician Signature – substitution permissible: _____ Date:_____

Note: The prescriber hereby appoints and authorizes employees of Geisinger Health Plan, Geisinger Quality Options, and/or Geisinger Indemnity Insurance Company to serve as his/her agent for the sole purpose of conveying to the specialty pharmacy, from and on behalf of such prescriber, prescriptions, medical necessity forms, and other patient information necessary to facilitate the procurement of the medication for the patient from such a specialty pharmacy. This Appointment and Authorization shall be in force until cancelled in writing by physician. Possession of a Health Plan insurance card does not guarantee coverage and this form is not a substitute for prior authorization.

For Health Plan internal use only:

Date received:_____ Date faxed to vendor:_____ Vendor:_____ Prior Auth obtained?: Y/N/NA
Member eligible?: Y/N Insurance ID #: _____ Group# _____Cardholder name_____