GHP Family Pharmacy Customer Service
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Geisinger

HYPOGLYCEMICS, TZDs PRIOR AUTHORIZATION FORM *(form effective 8/1/20)*

Prior authorization guidelines for Hypoglycemics, TZDs and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (*Submit documentation*):	Dx code (*required*:	
Does the beneficiary have a diagnosis of type 2 diabetes?	☐ Yes – *Submit documenation of diagnosis* ☐ No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*	
For a non-preferred Hypoglycemic, TZD: Please list the preferred Hypoglycemics, TZDs that the beneficiary has had a therapeutic failure, contraindication, or intolerance to. *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class*	*Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*	

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Has a history of trial and failure of maximum tolerated doses of metformin as evidenced by HbA1c results. Provide HbA1c value: _____
☐ Has a contraindication or intolerance to metformin
☐ Requires initial dual therapy with metformin based on HbA1c as defined by current ADA and/or AACE/ACE guidelines.
Provide HbA1c value: _____

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: