GHP Family Pharmacy Customer Service
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GeisingerHealthPlan.com

Geisinger

MACULAR DEGENERATION AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/1/20)*

Prior authorization guidelines for Macular Degeneration Agents 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:	
Contact's phone number:		State license #:	NPI:
LTC 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 this class.

Medication requested: *(all agents require prior authorization)*	☐ Eylea ☐ Lucentis	☐ Macugen ☐ Visudyne	☐ _____		
Strength:	Formulation:	☐ vial	☐ syringe	☐ _____	Frequency:
Eye(s) to be treated:	☐ right eye	☐ Left eye	☐ both eyes	☐ _____	Requested duration:

INITIAL requests

Does the beneficiary have one of the following diagnoses? *Indicate beneficiary's diagnosis.* ☐ diabetic macular edema ☐ diabetic retinopathy → ☐ with diabetic macular edema ☐ without diabetic macular edema ☐ macular edema following retinal vein occlusion (RVO) ☐ myopic choroidal neovascularization ☐ neovascular (wet) age-related macular degeneration (AMD) ☐ subfoveal choroidal neovascularization (predominantly classical)	☐ Yes – *Submit medical record documentation supporting diagnosis.* ☐ No – *Submit documentation of medical literature supporting the use of the requested agent for the beneficiary's diagnosis.*
What is the corresponding diagnosis code for the beneficiary's diagnosis?	Dx code *(required)*: _____
Has the beneficiary tried and failed or have a contraindication or intolerance to intravitreal bevacizumab?	☐ Yes – *Submit all supporting documentation of bevacizumab regimen and treatment outcome.* ☐ No ☐ Not clinically appropriate
For a non-preferred medication: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis?	☐ Yes ☐ No *Submit documentation.*

RENEWAL requests

List previous doses of the requested medication:

Right eye: _____

Left eye: _____

Has the beneficiary experienced a positive clinical response to previously administered doses of the requested medication?	☐ Yes ☐ No *Submit medical record documentation of beneficiary's response to treatment.*

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: