GHP Family Pharmacy Customer Service
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Danville, PA 17822

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GeisingerHealthPlan.com

Geisinger

ONCOLOGY AGENTS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Oncology Agents, Oral** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plans' website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

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

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis:		*Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.*	
Diagnosis code:			

INITIAL requests	
Has the beneficiary been taking the requested medication in the past 90 days?	☐Yes – *Submit documentation.* ☐No
For requests for a non-preferred medication: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medications in this class that are FDA-approved or medically accepted for the treatment of the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐Yes – *Submit all supporting documentation of drug regimen tried and treatment outcomes.* ☐No

RENEWAL requests	
Since the requested medication was started, has the beneficiary experienced a positive clinical response to therapy?	☐Yes – *Submit documentation of beneficiary's response to therapy.* ☐No

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: