GHP Family Pharmacy Customer Service
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Geisinger

POTASSIUM REMOVING AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/01/2020)*

Prior authorization guidelines for Potassium Removing 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:		NPI:	State license #:
LTC 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.

Drug requested:	Strength/formulation:	
Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
Is the medication being prescribed by or in consultation with a cardiologist or nephrologist?	☐Yes ☐No	
INITIAL requests		
Does the beneficiary have a recent serum potassium level(s) consistent with hyperkalemia? Serum potassium:_____Date obtained: _____ Serum potassium:_____Date obtained: _____	☐Yes ☐No *Submit Documentation*	
Has the beneficiary tried and failed a low potassium diet?	☐Yes ☐No *Submit Documentation*	
Has the beneficiary tried and failed a loop or thiazide diuretic (if clinically appropriate)? Diuretic(s) tried: _____ Reason diuretics cannot be tried: _____	☐Yes ☐No *Submit Documentation*	
Submit the beneficiary's complete medication list. If the beneficiary is taking any medications that are known to cause hyperkalemia, has the beneficiary tried and failed discontinuation or dose reduction of these medications?	☐Yes ☐No *Submit Documentation*	
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? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No *Submit Documentation*	
RENEWAL requests		
Has the beneficiary experienced a positive clinical response since starting the requested medication? Serum potassium:_____Date obtained: _____ Serum potassium:_____Date obtained: _____	☐Yes ☐No *Submit Documentation*	

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: