GHP Family Pharmacy Customer Service
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Geisinger

THALIDOMIDE AND DERIVATIVES PRIOR AUTHORIZATION FORM *(form effective 1/1/20)*

Prior authorization guidelines for **Thalidomide and Derivatives** 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

Drug Requested:	Dosage Form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis:		*Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.*	
Is the medication prescribed by or in consultation with an appropriate specialist (i.e., hematologist/oncologist)?		☐ Yes ☐ No	
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: