GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822

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GeisingerHealthPlan.com

UREA CYCLE DISORDER AGENTS PRIOR AUTHORIZATION FORM

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

☐ New request ☐ Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
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.

Drug requested:	Strength/formulation:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	

Is the medication being prescribed by or in consultation with a metabolic disorders specialist? ☐Yes ☐No *Submit documentation of consultation.*

INITIAL requests

Is the beneficiary's diagnosis supported by any of the following? *Check all that apply.*

- ☐ammonia levels
- ☐enzyme assays
- ☐genetic testing
- ☐plasma amino acid/urine orotic acid analyses
- ☐progress notes
- ☐other *(specify)*: _____

☐Yes ☐No *Submit documentation.*

Please list the preferred urea cycle disorder agents 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 this class.* _____ *Submit documentation.*

RENEWAL requests

Has the beneficiary experienced a positive clinical response since starting the requested medication? ☐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: