

Eastern Maine Healthcare Systems Employee Specialty Drug List and Form

Eastern Maine Healthcare Systems Employees and dependents have a pharmacy specialty vendor program.

The preferred specialty vendor is: Miller Drug
210 State Street
Bangor, ME 04401
207-947-8369

Please contact Miller Drug for all specialty vendor drug new starts (Note that these drugs may be available at other Miller Drug locations). In the event that Miller Drug is unable to obtain a specialty drug, they will contact Geisinger and arrangements will be made to obtain the drug from another source.

Note that all specialty vendor drugs have a maximum of 30 days supply per dispense unless otherwise noted.

Drugs that must be obtained via specialty vendor include:

Abilify Maintena *	Hetlioz*	Promacta *
Actemra IV *	Hizentra *	Ravicti *
Actemra SC *	Humate-P *	Rebif *
Actimmune *	Humatrope *	Reclast
Adagen	Humira *	Recombinate *
Adcetris	Hycamtin	Remicade *
Advate *	Hyqvia*	Remodulin *
Alecensa*	Ibrance *	Repatha *
Alphanate *	Iclusig*	Revlimid *
Alphanine SD *	Ilaris *	Rhogam
Ampyra *	Imbruvica *	Risperdal Consta *
Apokyn	Inlyta *	Rituxan *
Aralast *	Intron-A	Rubraca *
Aranesp *	Invega Sustenna *	Sabril *
Arcalyst *	Invega Trinza *	Saizen *
Arestin *	Iressa *	Signifor *
Aubagio *	Jakafi *	Simponi*
Avastin	Juxtapid *	Solesta *
Avonex *	Kadcyla *	Soliris *
Bebulin VH *	Kalydeco *	Sovaldi *
Benefix *	Keveyis *	Spinraza*
Benlysta *	Kineret *	Sprycel*

Berinert *	Kitabis Pak *	Stelara (given by provider) *
Betaseron	Koate *	Stelara (through pharmacy) *
Bethkis *	Kogenate *	Stivarga *
Bosulif *	Korlym *	Strensiq *
Botox *	Kuvan *	Sucraid *
Cabometyx*	Kynamro *	Supprelin LA *
Caprelsa *	Lemtrada *	Sustol*
Cayston *	Lenvima*	Sutent *
Chenodal *	Letairis *	Sylatron *
Cholbam *	Lonsurf*	Synagis *
Cimiza * (given by provider)	Lovenox	Synvisc
Cimzia * (through pharmacy)	Lucentis	Synvisc-One
Cinryze *	Lumizyme *	Tafinlar *
Cinqair*	Lupaneta *	Tagrisso *
Cometriq *	Lupron Depot	Taltz*
Copaxone	Lynparza*	Tarceva *
Cosentyx *	Makena *	Tecfidera
Cotellic*	Matulane	Technivie*
Cuvitru*	Mekinist *	Thalomid
Cystadane *	Mirena	Thiola *
Cystagon	Monoclate P *	Thyrogen
Cystaran *	Mononine *	Tobi *
Cytogam *	Myalept *	Tracleer
Daklinza*	Natpara*	Tykerb *
Daraprim	Neulasta *	Tysabri *
Duopa	Neupogen *	Tyvaso *
Dysport	Nexavar *	Uptravi*
Egrifta *	Nexplanon	Valchlor*
ElELYso *	Ninlaro *	Veltassa*
Eloctate *	Norditropin *	Veletri *
Enbrel *	Northera *	Venclexta*
Entyvio *	Novoseven *	Ventavis *
Epclusa*	Nucala *	Viekira Pak *
Epogen *	Nulojix *	Viekira XR*
Erivedge *	Nuplazid*	Vivitrol
Esbriet*	Nutropin *	Votrient *
Euflexxa	Ocaliva*	VPRIV *
Exjade *	Odomzo*	WinRho *
Exondys 51 *	Ofev*	Xalkori *
Extavia	Olysio *	Xenazine *
Feiba *	Orencia IV *	Xolair *
Ferriprox *	Orencia SC*	Xtandi *
Firazyr *	Orenitram*	Xyrem *
Flolan *	Orfadin *	Yervoy *
Forteo *	Orkambi *	Zaltrap *
Fuzeon	Otezla *	Zarxio*
Gammagard *	Oxaliplatin	Zavesca *

Gamunex *	Pegasys	Zelboraf *
Gattex *	Peg-Intron	Zemaira *
Gazyva *	Perjeta	Zepatier*
Genotropin *	Plegridy *	Zinbryta*
Gilenya	Pomalyst *	Zomacton *
Gilotrif*	Praluent *	Zorbtive *
Glassia *	Prialt *	Zydelig *
H.P Acthar *	Procrit *	Zykadia *
Harvoni *	Procysbi *	Zyprexa Relprevv *
Helixate FS *	Profilnine SD *	Zytiga *
Hemofil M *	Prolastin-C *	

* Indicates that a Prior Authorization is necessary. Prior Authorization must be obtained before submitting the prescription.

Drugs in black are typically self-administered and are covered through the pharmacy benefit. If you have any questions regarding coverage for these please contact the pharmacy dept. at (800) 988-4861.

Drugs in red are typically not self-administered and are covered through the medical benefit. If you have any questions regarding coverage for these please contact the medical management department at (800) 544-3907.

Geisinger Health Options (GHO) is a service available through Geisinger Indemnity Insurance Company, an affiliate of Geisinger Health Plan (GHP)

Last Updated 12/15/2016

Geisinger Health Plan Pharmacy Department

Specialty Pharmacy Vendor Drug Request Form

On behalf of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company

Instructions: All areas MUST BE COMPLETED in order to process the request. This form must be submitted with relevant clinical information for a Specialty Pharmacy Vendor drug that requires prior authorization (please fax clinical information and form to the appropriate fax number UM (570) 271-5534 and Pharmacy (570) 271-5610). If the request is approved, this form will serve as the prescription. If the requested drug does not require prior authorization, fax the completed form (prescription) to the Pharmacy Department. For questions regarding the form, please contact Geisinger Health Plan Pharmacy Department at (800) 988-4861.

Patient Information (*print legibly*)

Patient Name _____ D.O.B. _____ Weight _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Daytime Phone _____

Diagnosis _____ ICD-9 code _____ Health Plan Member ID # _____

Physician Information (*print legibly*)

Physician Name _____ State Lic # _____ NPI# _____

Office Address _____ City _____ State _____ Zip _____

DEA#: _____ Office Contact _____

Office Phone# _____ Office Fax # _____

Shipping Information (check appropriate location)

Physician office as listed above Patient's home as listed above Other (*Please provide address below*)

Prescription Information

New prescription

Refill prescription (*Required*) Date Needed _____

Medication Name	Dosage Form	Strength	Directions for Use	Quantity	# of Refills

Flushes (applicable to Hemophilia or Infusion patients only): Access: ☐ Peripheral ☐ Port ☐ PICC

☐ Heparin 10u/cc flush 5ml PFS

☐ Sodium Chloride 0.9% 10ml PFS

☐ Heparin 100 u/cc flush 5ml PFS

☐ Other _____

Signature Section-**Signature is required, no stamps. Prescriber certifies this is his/her full and usual signature**

Physician Signature-Dispense as Written: _____ Date _____

Physician Signature-Substitution Permissible: _____ Date _____

Note: The prescriber hereby appoints and authorizes employees of Geisinger Health Plan, Geisinger Quality Options, and/or Geisinger Indemnity Insurance Company to serve as his/her agent for the sole purpose of conveying to the specialty pharmacy, from and on behalf of such prescriber, prescriptions, medical necessity forms, and other patient information necessary to facilitate the procurement of the medication for the patient from such a specialty pharmacy. This Appointment and Authorization shall be in force until cancelled in writing by physician. Possession of a Health Plan insurance card does not guarantee coverage and this form is not a substitute for prior authorization.

For Health Plan internal use only:

Date received _____ Date faxed to vendor _____ Vendor _____ Prior Auth obtained? Y/N/NA
Member eligible Y/N Insurance ID # _____ Group# _____ Cardholder name _____