

ANALGESICS, ACUTE PAIN AGENTS PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Analgesics, Acute Pain 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>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total pages: _____		Prescriber name:	
Name of office contact:				Specialty:	
Contact's phone number:				NPI:	State license #:
LTC facility contact/phone:				Street address:	
Beneficiary name:				City/state/zip:	
Beneficiary ID#:		DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:		Strength:	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

<p>For ALL requests: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to both of the following?</p> <p><input type="checkbox"/> Acetaminophen <input type="checkbox"/> An NSAID</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Submit documentation.</i></p>
<p>For JOURNAVX (suzetrigine): Has the beneficiary received a 14-day supply of Journavx (suzetrigine) in the past 90 days?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Submit documentation.</i></p>
<p>For JOURNAVX (suzetrigine): If the beneficiary has used Journavx (suzetrigine) in the past, is the beneficiary experiencing a new episode of moderate to severe acute pain that is separate and distinct from the previous episode that was treated with Journavx (suzetrigine)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p><i>Submit documentation.</i></p>

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:
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