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____________________