Beebe Healthcare Employee
Formulary Information
Prior Authorization Procedure and Form

FORMULARY INFORMATION

Geisinger Health Options administers the pharmacy benefit for Beebe Healthcare. Please note that you can view the formulary online at www.thehealthplan.com/beebe

PHARMACY CUSTOMER SERVICE TEAM CONTACT INFORMATION

Telephone: (800) 988-4861 or (570)-271-5673; TDD/TTY 711

Fax: (570) 271-5610

Mailing address: Geisinger Health Plan
Pharmacy Department
Internal Mail Code 25-80
100 North Academy Avenue
Danville, PA 17822

SPECIALTY VENDOR MEDICATION PROGRAM

Certain medications require the use of a contracted specialty pharmacy vendor for purchase. There is a separate link on this site with more information and a list of the medications included.

STEP THERAPY

Some medications may require that other medications be tried prior to or concomitantly with the requested medication. The pharmacy claims system looks for a record of the required medications and if they are not found, medical documentation must be submitted showing use of these medications or rationale for skipping the step therapy medications.

NON-FORMULARY MEDICATION

The formulary is designed to meet most therapeutic needs of the population served by Geisinger Health Options. Occasionally, because of allergy, therapeutic failure, or a specific diagnostic-related need, formulary medications may not meet the special needs of an individual member. In these special instances, the prescribing physician may make requests to the Geisinger Health Plan Pharmacy Department for non-formulary or restricted medications. The prescribing physician will receive written documentation and/or a verbal response from the Geisinger Health Plan Pharmacy Department regarding the request.

PRIOR AUTHORIZATION

To promote the most appropriate utilization, select medications may require prior authorization to be eligible for coverage under the member's prescription benefit. In order for a member to receive coverage for a medication requiring prior authorization, the prescribing physician must obtain prior authorization by contacting the Geisinger Health Plan Pharmacy Department at the address, telephone, or fax number above. Submission of medical documentation is required. Please note that the attached form may be used for prior authorization requests. The Drugs requiring prior authorization can be found by viewing the formulary at www.thehealthplan.com\cchs

Last Updated 01/28/14

GEISINGER HEALTH OPTIONS®

Prior Authorization Request Form

Please fax completed form to 570-271-5610, Medical documentation may be requested

IF REQUEST IS MEDICALLY URGENT, PLEASE REQUEST AN EXPEDITED REVIEW
ANY QUESTIONS PLEASE CALL GHP PHARMACY DEPARTMENT AT 1-800-988-4861
MONDAY-FRIDAY 8am-5pm

This form cannot be used to request:

- Medicare non- covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain, or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations) (Applicable to Gold products only)
- Biotech or other specialty drugs for which drug-specific forms are required. Please refer to http://www.thehealthplan.com/providers_us/provider.cfm for the applicable order form. (Applicable to all products)

Patient Information				Prescriber Information	
Patient Name:				Prescriber Name:	
Member ID#:				NPI# (if available):	
Address:				Address:	
City:	State:			City:	State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:		Zip:
Sex (circle): M F	DOB:			Contact Person:	

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:	Date:	

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure)
Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
Specify below: Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage
Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

Request for formulary tier exception, applicable to Medicare Beneficiaries with Part D coverage Only
Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other: _____ Explain below

REQUIRED EXPLANATION: _____

_____

_____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]. BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Instructions for Completing the Form

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.
NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

Geisinger Health Plan
Attn: Pharmacy Department 25-80
100 N. Academy Avenue
Danville, PA 17822
Fax: 570-271-5610

Clinical Management Procedures*

The Health Plan's[1] Pharmacy Department maintains a process by which Health Care Providers can:

• Request precertification for medication(s) designated in the Formulary by an asterisk (*) as requiring such

• Request a Formulary exception for specific drugs, drugs used for an off-label purpose, and biologicals and medication(s) not included in the Health Plan's then current drug Formulary

Formulary exception requests will be evaluated and a determination of coverage made utilizing all the following criteria:

1. Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract)

2. Utilization of the requested agent for a clinically proven treatment indication or diagnosis

3. Therapeutic failure, intolerance or contraindication to use of Formulary agent and/or agents designated as therapeutically equivalent

4. Appropriateness of the non-Formulary agent compared with available Formulary agents, including but not limited to:
a. Safety

b. Efficacy

c. Therapeutic advantage as demonstrated by head to head clinical trails

d. Meets Health Plan criteria for drug or drug class Formulary exception

* Please refer to the Health Plan's Provider Guide and Formularies for further information.

Please note that the Formulary Exception / Prior Authorization process is an independent process and is not in conjunction with the Specialty Pharmacy Drug Program.

[1] Geisinger Health Plan and Geisinger Indemnity Insurance Company shall be collectively referred to as "Health Plan."

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For Health Plan internal use only:
Date received_____ Date reviewed_____ Request approved: Y / N / NA