GHP Family Specialty Drug List/Procedure

Medical Management:	**Pharmacy Customer Service**:
Phone: (800) 544-3907 option 2	Phone: (855) 552-6028
Fax: (570) 271-5534	Fax: (570) 271-5610

Drugs included in Geisinger Health Plan Specialty Pharmacy Drug Program	**Prior Authorization** required if marked. Contact the Medical Management Department.	**Prior Authorization** required if marked. Contact the Pharmacy Department.	**Specialty Pharmacy Provider Status per GHP**
Abilify Maintena	**X**		**Voluntary**
Actemra IV	**X**		**Voluntary**
Actemra Self Injectable		**X**	**Mandatory**
Actimmune		**X**	**Mandatory**
Adagen	**X**		**Voluntary**
Adcetris	**X**		**Voluntary**
Advate	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Alphanate	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Alphanine SD	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Ampyra		**X**	**Mandatory**
Apokyn		**X**	**Mandatory**
Aralast NP	**X**		**Mandatory**
Aranesp	**X (if physician injects)**	**X (if member injects)**	**Voluntary**
Arcalyst		**X**	**Mandatory**
Arestin	**X**		**Voluntary**
Avonex		**X**	**Mandatory**
Bebulin	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Benefix	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Berinert	**X**		**Mandatory**
Betaseron			**Mandatory**
Botox	**X**		**Voluntary**
Caprelsa		**X**	**Mandatory**
Cayston		**X**	**Mandatory**
Cerezyme	**X**		**Mandatory**
Cimzia	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Cinryze	**X**		**Mandatory**
Cometriq		**X**	**Mandatory**
Copaxone			**Mandatory**
Cystadane		**X**	**Mandatory**
Cystagon			**Mandatory**
Cystaran		**X**	**Mandatory**
Cytogam	**X**		**Voluntary**
Daraprim		**X**	**Mandatory**
Elelyso	**X**		**Mandatory**
Eloctate	**X (if physician injects)**	**X (if member injects)**	**Mandatory ***
Enbrel		**X**	**Mandatory**
Entyvio	**X**		**Voluntary**
Epogen	**X (if physician injects)**	**X (if member injects)**	**Voluntary**
Erivedge		**X**	**Mandatory**
Euflexxa			**Voluntary**

Exjade		X	Mandatory
Feiba	X (if physician injects)	X (if member injects)	Mandatory *
Firazyr		X	Mandatory
Flolan	X		Mandatory
Forteo		X	Mandatory
Fuzeon			Mandatory
Gammagard	X		Voluntary
Gamunex-C	X		Voluntary
Gattex		X	Mandatory
Genotropin		X	Mandatory
Gilenya			Mandatory
Glassia	X		Mandatory
H.P. Acthar		X	Mandatory
Harvoni		X	Mandatory
Helixate FS	X (if physician injects)	X (if member injects)	Mandatory *
Hemofil M	X (if physician injects)	X (if member injects)	Mandatory *
Hizentra	X		Voluntary
Humate-P	X (if physician injects)	X (if member injects)	Mandatory *
Humatrope		X	Mandatory
Humira		X	Mandatory
Hycamtin			Mandatory
Ibrance		X	Mandatory
Ilaris	X		Mandatory
Implanon			Mandatory
Inlyta		X	Mandatory
Intron-A			Voluntary
Invega Sustenna	X		Voluntary
Invega Trinza	X		Voluntary
Jakafi		X	Mandatory
Kalydeco		X	Mandatory
Kineret		X	Mandatory
Koate-DVI	X (if physician injects)	X (if member injects)	Mandatory *
Kogenate FS	X (if physician injects)	X (if member injects)	Mandatory *
Korlym		X	Mandatory
Kuvan		X	Mandatory
Kynamro		X	Mandatory
Letairis		X	Mandatory
Lucentis			Voluntary
Lumizyme	X		Mandatory
Lupron Depot			Voluntary
Makena	X		Voluntary
Matulane		X	Mandatory
Mekinist		X	Mandatory
Monoclate-P	X (if physician injects)	X (if member injects)	Mandatory *
Mononine	X (if physician injects)	X (if member injects)	Mandatory *
Myalept		X	Mandatory
Neulasta	X (if physician injects)	X (if member injects)	Voluntary
Neupogen	X (if physician injects)	X (if member injects)	Voluntary
Nexavar		X	Mandatory
Norditropin		X	Mandatory
Northera		X	Mandatory
Novoseven RT	X (if physician injects)	X (if member injects)	Mandatory *
Nulojix	X		Mandatory
Nutropin AQ		X	Mandatory
Olysio		X	Mandatory
Onsolis		X	Mandatory

Orencia IV	X		Voluntary
Orencia Self Administered		X	Mandatory
Orkambi		X	Mandatory
Otezla		X	Mandatory
Pegasys			Mandatory
PegIntron			Mandatory
Perjeta	X		Mandatory
Plegridy		X	Mandatory
Pomalyst		X	Mandatory
Praluent		X	Mandatory
Prialt	X		Voluntary
Procrit	X (if physician injects)	X (if member injects)	Voluntary
Procysbi		X	Mandatory
Profilnine	X (if physician injects)	X (if member injects)	Mandatory *
Prolastin-C	X		Mandatory
Promacta		X	Mandatory
Ravicti		X	Mandatory
Rebif		X	Mandatory
Recombinate	X (if physician injects)	X (if member injects)	Mandatory *
Remicade	X		Voluntary
Remodulin	X (if physician injects)	X (if member injects)	Mandatory
Repatha		X	Mandatory
Revlimid		X	Mandatory
Rhogam			Voluntary
Risperdal Consta	X		Voluntary
Sabril		X	Mandatory
Saizen		X	Mandatory
Signifor		X	Mandatory
Signifor LAR		X	Mandatory
Solesta	X		Voluntary
Soliris	X		Mandatory
Sovaldi		X	Mandatory
Stelara	X (if physician injects)	X (if member injects)	Mandatory *
Sucraid		X	Mandatory
Supprelin LA	X		Mandatory
Sylatron		X	Mandatory
Synagis	X		Voluntary
Synvisc			Voluntary
Synvisc-One			Voluntary
Tafinlar		X	Mandatory
Tarceva		X	Mandatory
Tecfidera			Mandatory
Tev-Tropin		X	Mandatory
Thalomid		X	Mandatory
Thyrogen			Voluntary
Tobi/Tobi Podhaler		X	Mandatory
Tracleer		X	Mandatory
Tykerb		X	Mandatory
Tysabri	X		Mandatory
Tyvaso		X	Mandatory
Veletri	X		Mandatory
Ventavis		X	Mandatory
Viekira Pak		X	Mandatory
Vivitrol	X		Voluntary
VPRIV	X		Voluntary
WinRho	X		Voluntary

Xalkori		X	**Mandatory**
Xenazine		X	**Mandatory**
Xolair	X		**Mandatory**
Xtandi		X	**Mandatory**
Xyrem		X	**Mandatory**
Zavesca		X	**Mandatory**
Zelboraf		X	**Mandatory**
Zemaira	X		**Mandatory**
Zorbtive		X	**Mandatory**
Zyprexa Relprevv	X		**Voluntary**
Zytiga		X	**Mandatory**
*Use of the Specialty Pharmacy Drug Program is mandatory only when medication will be self-administered by the member at home. Use of the Specialty Pharmacy Drug Program is not mandatory if the physician elects to buy and bill the medication.			
Last Updated 01/08/2016			

Quick Reference Sheet for GHP Family Specialty Vendor Drug Program

Step 1: Is the prescribed drug on the attached Specialty Vendor List?

- If yes, proceed to Step 2
- If no, use of a specialty vendor is not required.

Step 2: Determine if prior authorization is required on the applicable drug.

- Refer to the attached list to determine if a Prior Authorization is required (marked with an asterisk).
- If prior authorization is not required, proceed to Step 3
- If prior authorization is required, determine if the drug is a pharmacy benefit or medical benefit. If a pharmacy benefit (drug is black on the Specialty Vendor List), follow the steps outlined in the GHP Family Prior Authorization Procedure. If a medical benefit (drug is red on the Specialty Vendor List) please contact Geisinger medical management. Upon prior authorization approval proceed to Step 3. Approval or denial notification will be distributed to the requesting provider.

Step 3: Fax a completed Specialty Vendor Request Form to Geisinger Health Plan Pharmacy Department at (570) 271-5610

Step 4: Upon receipt of medication, store medication in approved area and administer as prescribed.

Any questions, please contact GHP Family Pharmacy Department at 1-855-552-6028, M, T, TH, FR 8am-5pm AND W 8am-8pm. The medical management department can be reached at (800) 544-3907.

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 (855) 552-6028.

Patient Information ***(print legibly)***

Patient Name____D.O.B.______________Weight_______________

Address____City_________________State________Zip________________

Home Phone_______________________________________Daytime Phone _______

____ Diagnosis_ICD-9 code__

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____________________