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_____