

**BENZODIAZEPINES PRIOR AUTHORIZATION FORM** (form effective 1/8/2024)

Prior authorization guidelines 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		# of 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:
Beneficiary address:			Beneficiary phone number:	

**CLINICAL INFORMATION**

Benzodiazepine requested:		Strength:	Dosage form (capsule, tablet, etc.):	
Directions:			Quantity:	Refills:
Diagnosis (submit documentation):			DX code ( <u>required</u> ):	
If the requested benzodiazepine is non-preferred, did the beneficiary try and fail the preferred benzodiazepines approved or medically accepted for the treatment of their condition? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for the list of preferred and non-preferred drugs.			<input type="checkbox"/> Yes – Submit documentation. <input type="checkbox"/> No	

**Benzodiazepines (preferred and non-preferred) require prior authorization in the scenarios listed below. Check all options that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each.**

<input type="checkbox"/> The beneficiary is <b>under 21 years of age</b> and: <input type="checkbox"/> Has a diagnosis of ( <i>check all that apply</i> ): <input type="checkbox"/> seizure disorder <input type="checkbox"/> spastic disorder <input type="checkbox"/> chemo-induced nausea/vomiting <input type="checkbox"/> dystonia <input type="checkbox"/> cerebral palsy <input type="checkbox"/> catatonia <input type="checkbox"/> Has symptoms of severe acute anxiety AND: <input type="checkbox"/> Has chart documented evidence of a comprehensive evaluation <input type="checkbox"/> Is prescribed the benzodiazepine by or in consultation with a psychiatrist <input type="checkbox"/> Is receiving palliative care
<input type="checkbox"/> The beneficiary is <b>taking 2 or more different benzodiazepines concurrently (therapeutic duplication)</b> AND: <input type="checkbox"/> Concomitant use of the benzodiazepines is supported by national treatment guidelines or medical literature <input type="checkbox"/> Is being titrated to or tapered from one benzodiazepine to the other

The beneficiary **filled 2 or more prescriptions for any benzodiazepine** in the past 30 days AND:

The prescriptions are for the same benzodiazepine, strength, and directions for use

Each prescription was filled for <30 days' supply

Other reason for filling >1 benzodiazepine prescription in the past 30 days – specify: \_\_\_\_\_

The prescriptions were prescribed by the same prescriber

The prescriptions were prescribed by different prescribers AND:

All prescribers are aware of the other benzodiazepine prescriptions

The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed medical literature or national treatment guidelines

The beneficiary has a **concurrent prescription for another controlled substance** and: The

prescriptions were prescribed by the same prescriber

The prescriptions were prescribed by different prescribers All

prescribers are aware of the other prescriptions

Has an acute need for the requested benzodiazepine – specify: \_\_\_\_\_

**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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