Insert Plan Logo Here

Universal Pharmacy Prior Authorization Form

Confidential Information

Patient Name		
Patient DOB	Patient ID Number	
Prescriber Name	Specialty	
Prescriber Phone ( )	Prescriber Fax ( )	NPI#
Prescriber Address		
City	State	Zip
Medication Name and Strength Requested: □ Brand Medically Necessary request (Rationale required below)		
Directions:	Quantity Requested:	
Anticipated Length of Therapy: ☐ _____ Days ☐ 3 Months ☐ 6 Months ☐ 12 Months		
Diagnosis:		
Preferred Medications tried/previous therapy, please include strength, frequency and duration:		
Rationale and/or additional information, which may be relevant to the review of this prior authorization request:		
Prescriber Signature	Date	

Please fax this form to: 855-851-4058

PerformRx
200 Stevens Drive
Philadelphia, PA 19113

PerformRx Provider Services:

Phone: (insert phone number)