Universal Pharmacy Prior Authorization Form

(confidential information)

Please type this document to ensure accuracy and to expedite processing. All fields must be completed for the request to be processed. Please make a selection where applicable throughout the document.

☐ **Urgent**

Member name:			
Member date of birth:	Height:	Weight:	Member ID number:
Prescriber name:			Specialty:
Prescriber phone:	Prescriber fax:		NPI number:
Prescriber address:			
City:	State:		ZIP code:
Medication name:	Strength requested:		Dosage form:
☐ Brand medically necessary request (rationale required below)			
Directions for use:			Quantity per day:
Therapy status: ☐ Initial ☐ Continuation If "Continuation," provide therapy start date: 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:

Fax this form to: Standard: **1-844-470-2506** Urgent: **1-844-470-2509**
Call PerformRx℠ Provider Services: **1-833-733-7977**