Universal Pharmacy Prior Authorization Form

(confidential information)

AmeriHealth Caritas Next

A product of AmeriHealth Caritas Florida, Inc.

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 **1-844-470-2507** Urgent **1-844-470-2510**
Call PerformRx℠ Provider Services: **1-833-982-7977**