

# UNIVERSAL PHARMACY ORAL PRIOR AUTHORIZATION FORM

(form effective 7/21/2020)



**Keystone First**  
Community HealthChoices

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

Fax to PerformRx<sup>SM</sup> at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

CONFIDENTIAL INFORMATION			
Patient name:		Patient ID#:	DOB:
Prescriber name:		Prescriber specialty:	
Prescriber phone:	Prescriber fax:	Prescriber license #:	
Prescriber address:			
City:		State:	Zip:
Dispensing pharmacy name:		Dispensing pharmacy phone:	Dispensing pharmacy fax:
Medication Name and Strength Requested:			
Directions:		Quantity requested:	
Anticipated Length of Therapy: <input type="checkbox"/> ___ Days <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months			
Diagnosis:			
Preferred Medications tried/previous therapy, please include strength, frequency, and duration: (If medications were tried prior to enrollment, or if office samples were given, please include.)			
Rationale and/or additional information, which may be relevant to the review of this prior authorization request:			
Prescriber signature:			Date: