



**Universal Pharmacy  
Oral Prior Authorization  
Form**  
Confidential Information

Patient Name		
Patient DOB		Patient ID Number
Physician Name		Specialty
Phone	Fax	License #
Physician Address		
City	State	Zip
Medication Name and Strength Requested		
Directions		
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: <i>(If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs)</i>		
Rationale and/or additional information, which may be relevant to the review of this prior authorization request:		
Physician Signature		Date

Please return this form to:

**PerformRx  
AmeriHealth Mercy  
200 Stevens Drive  
Philadelphia, PA 19113**

Or FAX to **1-888-981-5202**

**Injectable Requests-Please call  
1-866-610-2774**