AmeriHealth Caritas
District of Columbia

☐ Medicaid member
☐ Alliance Member

Universal Pharmacy
Prior Authorization Form

Confidential Information

Patient Name Patient DOB		Patient ID Number
Physician Name		Specialty
Phone	Fax	NPI #
Physician Address		
City	State	Zip
Medication Name and Strength Requested		
Directions		
Anticipated Length of Therapy:		
☐ Days	☐3 Months	☐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 chart notes and/or sample logs)*		
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 Caritas District of Columbia
200 Stevens Drive
Philadelphia, PA 19113

FAX to 1-855-811-9332