AmeriHealth Caritas Louisiana

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
Pharmacy Name	Pharmacy Phone	Pharmacy Fax
Medication Name and Strength Requested		
Directions		Quantity/Day Supply
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

***Providers please note patients are eligible for one time emergency temporary supply.**

Please return this form to:

PerformRx
200 Stevens Drive
Philadelphia, PA 19113

or FAX to: 1-855-452-9131

Provider Services Help Desk
1800-684-5502

Revised: 10/2013