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:

FAX to 1-855-811-9332

PERFORMRx
AmeriHealth Caritas District of Columbia
200 Stevens Drive
Philadelphia, PA 19113