Universal Pharmacy Oral Prior Authorization Form

Confidential Information

Keystone First

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:		
□ 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*		
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
Keystone First
200 Stevens Drive
Philadelphia, PA 19113

Or FAX to **1-215-937-5018**

Injectable Requests-Please call
1-800-588-6767

Made Fillable by eForms