SAN FRANCISCO HEALTH PLAN
Here for you

Universal Pharmacy Prior Authorization Form

Confidential Information

Patient Name		
Patient DOB	Patient ID Number	
Prescriber Name	Specialty	
Prescriber Phone ( )	Prescriber Fax ( )	NPI#
Prescriber Address		
City	State	Zip
Pharmacy Name	Pharmacy Phone ( )	Pharmacy Fax ( )
Medication Name and Strength Requested: ☐ Brand Medically Necessary request (Rationale required below)		
Directions and Quantity Requested:		
Anticipated Length of Therapy: ☐ _____ Days ☐ 3 Months ☐ 6 Months ☐ 12 Months		
Diagnosis:		
Preferred Medications tried/previous therapy, please include strength, frequency and duration:		
Rationale and/or additional information, which may be relevant to the review of this prior authorization request:		
Prescriber Signature	Date	

Please fax this form to:

Standard Request: 1-855-811-9330
Urgent Request: 1-855-811-9331

PerformRx Provider Services:

Phone: 1-888-989-0091