



**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:		
<input type="checkbox"/> Brand Medically Necessary request (Rationale required below)		
Directions and Quantity Requested:		
Anticipated Length of Therapy:		
<input type="checkbox"/> _____ Days <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 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