UNIVERSAL PHARMACY ORAL PRIOR AUTHORIZATION FORM

(form effective 7/1/2025)

Pennsylvania's Children's Health Insurance Program **We Cover All Kids.**

Keystone First

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.

PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-833-873-2908**, or to speak to a representative call **1-844-779-2447**.

CONFIDENTIAL INFORMATION			
Patient name:		Patient ID#:	DOB:
Prescriber name:		Prescriber specialty:	
Prescriber phone:	Prescriber fax:	Prescriber license #:	
Prescriber address:			
City:		State:	Zip:
Dispensing pharmacy name:		Dispensing pharmacy phone:	Dispensing pharmacy fax:
Medication Name and Strength Requested:			
Directions:		Quantity requested:	
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:			
Prescriber signature:			Date: