Drug Prior Authorization Request Form

Select Health
of South Carolina, Inc.
An AmeriHealth Mercy Company

Member Information

Member name ______________________ Today's date __________

Select Health member ID# ______________________ Birthdate __________

Physician Information

Physician name ______________________ Physician ID# ______________________

Address ______________________ Phone __________

City, state, zip ______________________ Fax __________

Request Information

Medication name and strength requested

Directions

Anticipated length of therapy: ☐ Days __________ ☐ Months __________ ☐ Chronic maintenance therapy

Diagnosis

Preferred medication tried/previous therapy for this diagnosis (PLEASE include strength, frequency and duration)

Rationale for selecting this medication (PLEASE do not answer "DRUG OF CHOICE")

Sign Here & Form Submittal Instructions

Authorizing signature ______________________

Please return this form to:

Select Health/PerformRx Pharmacy Services
200 Stevens Drive
Philadelphia, PA 19113
Fax 866.610.2775

Drug Prior Auth Form Revision 07/2010