Pharmacy Services Review – Prior Authorization Required

Please have your physician complete this form and submit via fax or email to: 540-777-7184 priorauth@universalrx.com. Once the form is received, this request will be reviewed, and a Universal Rx Customer Service Representative will contact you to discuss the next steps. If you have questions about this form, please call 540-777-7179 or email urx@universalrx.com.

Date: _____

Patient Name:_____ Patient ID:_____

Patient Phone:_____ Patient Email: (___) ____ - _____

Physician Name: _____ Physician Phone: _____

Demographic Data

Patient Date of Birth:_____ Female_____ Male _____ Weight:_____ Height: _____

Drug Name: _____

Diagnosis: _____

Please provide clinical documentation for the use of this medicine by this patient (including appropriate clinical chart documents for the drug requested)

_____

_____

Please identify previously used clinical alternative(s) that have been unsatisfactory for this patient:

_____

_____

Anticipated Length of Therapy: _____

Please attach any supporting clinical information that may be useful for this review

Prescriber's Signature:_____

UPIN #: _____ Specialty:_____

Name of person completing form if not physician:_____
(Please print)

Signature of Person completing form if not physician:_____

Thank you for completing our request for additional information.