Pharmacy Services Review – Prior Authorization Required

Please have your physician complete this form and submit via fax or email to 540-777-7184 or 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.

Date: _____

Patient Name:_____Patient ID/Sponsor #_____

Patient Phone:_____Patient Email: _____

Physician Name: _____Physician Phone/Fax: _____

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:_____

NPI #: _____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.