Pharmacy Services Review – Prior Authorization Required

Please have your physician complete this form and submit via fax to: 540-777-7184. 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 priorauth@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:_____

Required Clinical Support Documents – The requested use of the drug identified above will be examined in accordance with widely accepted authorization criteria. In order to complete the review process applicable medical chart notes and/or laboratory test results and/or other survey or screening instruments that contribute to diagnosis confirmation are needed. Please include this information with the reply to this fax request. Not receiving this information will delay completion of the review.

_____

_____

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

_____

_____

Anticipated Length of Therapy: _____

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.