



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.