Prior Authorization Request Form

PLEASE FAX OR EMAIL THIS REQUEST FORM TO 540-777-7184, URX@UNIVERSALRX.COM

The prescriber must complete this form in full to avoid processing delay. Please attach any information that should be considered with this request. Should you have questions regarding this form please call 540-777-7179.

Patient Information

Patient Name:	
Date of Birth:	Member ID #:
Plan Name: *(If Known)*	Rx Group #:

Prescriber Information

Prescriber's Name:			
DEA/Licensing Number:	NPI Number:	Office Phone:	Fax:
Clinic Name:	Contact Name:		
Address:	City:	State:	Zip:
Pharmacy:	Phone:	Fax:	

Drug Information

Reason for Authorization Request (Leave blank if unknown)

☐ Prior Authorization for clinical criteria
☐ Quantity Limit override
☐ Step Therapy
☐ Non-formulary medication

Requested Drug Name and Strength:		Quantity:	ICD-9
Directions:		Start Date of Therapy:	Diagnosis:
Previous Drugs Tried and Reason for Past Failures: (OTC products may be included)			
Trial #1 - Drug Name:	Dosage:	Start Date:	Date Discontinued:
Reason for Discontinuation:			
Trial #2 - Drug Name:	Dosage:	Start Date:	Date Discontinued:
Reason for Discontinuation:			
Trial #3 - Drug Name:	Dosage:	Start Date:	Date Discontinued:
Reason for Discontinuation:			
List any contra-indications to formulary alternative or generic medications:			
Significant lab values:			
Quantity Limit Exception: (please provide dosing schedule and tapering information):			
Requesting Provider's Signature		Date	

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