EXEMPLAR
HEALTH BENEFITS ADMINISTRATOR

Prior Authorization Information Request Form

Patient Information

Name:_____ Date of Birth: _____
Gender: _____

ID#_____Group#_____
Address: _____ Phone: _____

Physician /Clinic Information

Prescriber Name: _____

Physician NPI: _____

Address: _____City, State, Zip:_____

Contact Name: _____

Phone: _____Secure Fax: _____

Drug Requested and Diagnosis

Medication Name: _____

Confirm Dosage type: _____

Quantity Requested: _____

Patient's ICD -10 Diagnosis: _____

Has the patient previously tried and failed any other medication(s) related to this diagnosis? _____

Please list other medication(s) _____

Does the patient have a contraindication/intolerance to any other medications related to this diagnosis? Yes No
If yes, please list _____

Please list other medication(s) _____

Certification and Signature: _____

Internal Review Approved _____ Denied_____ explanation below
_____
_____
_____
_____

Date_____ Reviewer Name _____
Signature _____ Title _____