EXEMPLAR
HEALTH BENEFITS ADMINISTRATOR

Prior Authorization Information Request Form

Please email completed form to prior.auth@exemplarhba.com or fax to (888) 457-1332.

Patient Information

Name:_____ Date of Birth: _____ Gender: _____
ID#_____ Group#_____
Address: _____ City, State, Zip:_____
Phone: _____

Physician /Clinic Information

Prescriber Name: _____
Physician NPI: _____
Address: _____City, State, Zip:_____
Contact Name: _____
Contact Phone: _____ Secure Fax: _____

Medication Requested:_____

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) _____

Is this medication medically necessary for the above member? __Yes __No

Certification Signature: _____ Date:_____

Internal Review Approved _____ Denied_____ (explanation below)
_____
_____
_____
_____

Date_____ Reviewer Name _____
Signature _____ Title _____