PRIOR AUTHORIZATION REQUEST (SAMPLE)

Document Version: 1.0
Date: 2026-02-04

Patient & Plan (DE-IDENTIFIED)

Patient ID: PATIENT-0001
Plan: Sample Health Plan PPO
Member Group: GRP-100

Medication Request

Requested Drug: Examplemab 150 mg/mL injection (brand: EXAMPLEBIO)
NDC: 00000-0000-00
Dose/Frequency: 150 mg SC every 4 weeks
Quantity: 1 syringe per 28 days
Route: Subcutaneous
Site of Care: Outpatient

Clinical Information

Diagnosis: Condition X (ICD-10: X00.0)
Previous therapies tried: Therapy A (failed), Therapy B (intolerant)
Baseline labs: Provided (see attached)
Provider Attestation: Patient meets criteria as documented.

Coverage Criteria (SAMPLE)

Eligibility requirements:
- Age >= 18 years
- Confirmed diagnosis of Condition X
- Documentation of inadequate response to at least 1 standard therapy

Approval rules:
- Initial approval: 6 months
- Renewal requires evidence of clinical benefit and adherence
- Quantity limit: 1 per 28 days

Administrative notes:
- Step therapy may apply
- Prior authorization required
- Specialty pharmacy only

PHARMACY AGREEMENT (SAMPLE EXCERPT)

This sample excerpt simulates terms commonly found in pharmacy agreements.

Dispensing pharmacy: Sample Specialty Pharmacy
Shipping: Temperature-controlled packaging required
Refills: Not automatic; provider confirmation required for renewals

Auditability:
- All approvals must reference evidence in submitted documentation.
- Decisions must be reproducible and logged.

Signatures: (sample)
Provider Name: SAMPLE PROVIDER
Signature Date: _____