PRODIGY CARE SERVICES
5090 BALCONES DR., STE. 100
AUSTIN, TX 78713

PRIOR AUTHORIZATION REQUEST FORM

INSTRUCTIONS

This form is to be used by prescribers only. Please complete this form for prospective, concurrent, and retrospective reviews. To avoid delays, please attach all applicable patient medical records including chart notes, laboratory, and imaging results. Please complete this form and return either by e-mail to providers@prodigyrx.com, fax:1 (800) 909-4521 or by postal mail: 5090 Richmond Ave, #163, Houston, TX 77056. Please note that information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA. If you have any questions about regarding this form, please dial 1 (800) 684-8749.

REASON FOR THIS FORM

Please select: ☐ Initial Request ☐ Renewal/Continuation of Therapy Request
Please select type of Prior Authorization requested (select all that apply): ☐ Formulary Exception ☐ Quantity Limit ☐ Compound Drug Exception ☐ Drug Tier ☐ Copay Exception ☐ Other: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Drug Allergies:	Height/Weight:	Gender: ☐ Male ☐ Female	

INSURANCE INFORMATION

Member ID Number:	Group Number:

PRESCRIBER INFORMATION

Prescriber Name:	Prescriber NPI#:	DEA/xDEA:	Specialty:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	
Contact Person (if different from prescriber):			
Prescriber's or Authorized Representative's Signature:		**Date: _____**	

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MEDICATION INFORMATION

Patient Diagnosis (ICD-10) Code(s):		
Medication Requested:		
Strength:	Quantity/month:	Sig/Directions/Frequency
Route of Administration	Expected Duration of Therapy	

PREVIOUS MEDICATION TRIED AND/OR FAILED

Has the patient tried this medication in the past 6 months? ☐ Yes ☐ No Start date: _____

Please list previous therapies tried and/or failed:

Drug Name	Strength/Frequency	Dates of Use	Results/Outcomes
1.			
2.			
3.			
4.			

Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current clinical literature such as AHFS, Micromedex, or current accepted clinical guidelines? ☐ Yes ☐ No

Has the patient had appropriate laboratory and/or genetic testing to support the diagnosis? ☐ Yes ☐ No

Please provide any additional details that you believe is necessary to facilitate the review of this authorization request)