GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Universal 17-P Authorization Form

Fax the COMPLETED form OR call the plan with the requested information.

Phone: 1-866-525-5827 Fax: 1-888-491-9742

Date of Request for Authorization: _____

Patient/Member Name: _____ DOB: _____

Address (Street, Apt. #): _____

City/State/Zip: _____

Phone: _____ Medicaid #: _____ MCO ID #: _____

Pregnancy Information and History:

G___ T___ P___ A___ L___ Note: A=abortion (spontaneous and medically induced) EDC_____

Experiencing Preterm Labor: ☐ Yes ☐ No

☐ Singleton Pregnancy ☐ Multiple Pregnancy

Date When Patient Will be at 16 Weeks Gestation: _____

Major Fetal or Uterine Anomaly	☐ Yes ☐ No
Patient has a history of prior spontaneous singleton preterm birth between 16-36.6 weeks	☐ Yes ☐ No
Delivery was due to preterm labor or PPROM even if it resulted in a C-section	☐ Yes ☐ No
Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc.	☐ Yes ☐ No
Current or history of thrombosis or thromboembolic disorders	☐ Yes ☐ No
Known or suspected breast cancer, other hormone sensitive cancer or history of these conditions	☐ Yes ☐ No
Undiagnosed abnormal vaginal bleeding unrelated to pregnancy	☐ Yes ☐ No
Cholestatic jaundice of pregnancy	☐ Yes ☐ No
Liver tumors, benign or malignant, or active liver disease	☐ Yes ☐ No
Uncontrolled hypertension	☐ Yes ☐ No

Medication Allergies: (if none put N/A)

_____

Other Pertinent Clinical Information: (if none put N/A)

_____

Patient/Member Name: _____ **DOB:** _____
Address (Street, Apt. #): _____
City/State/Zip: _____

Does the patient meet FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)?

☐ Yes ☐ No

Current Gestational Age: _____ week(s) _____ days

Date Recorded: _____

Is the patient currently receiving Makena? ☐ Yes ☐ No

Is the patient currently receiving compounded HPC (17P)?

☐ Yes ☐ No

Complete and Sign Rx:

_____
Prescriber's Name (Last, First)

_____
Address

_____
City, State, Zip

_____
Practice Name Office Phone# Office Fax #

_____
NPI # Office Tax ID #

_____
Medicaid Provider #

_____
Office Contact(s) Direct Phone #

_____
After-hours Phone # Email

ICD-10 Code:

☐ O09.212 - Supervision of pregnancy with history of preterm labor, second trimester

☐ O09.213 - Supervision of pregnancy with history of preterm labor, third trimester

☐ O09.219 -Supervision of pregnancy with history of preterm labor, unspecified trimester

Preferred Method of Communication:

☐ Phone ☐ Fax ☐ Email

Rx:

☐ hydroxyprogesterone caproate injection 250 mg/mL (J1725) (Makena)

☐ Compounded 17P

☐ Dispense 4 x 1 mL single-dose, preservative-free vials (64011-247-02) X _____ refills

☐ Sig: Inject 1 mL IM each week

☐ 18-g needles & 3 mL syringe _____ #

☐ 21-g 1 ½ needle _____ #

Please Ship To:

☐ Prescriber ☐ Patient

Preferred Injection Setting:

☐ Healthcare Provider Office

☐ Home Health Care agency, if approved by insurance

Write in agency name:

_____

Desired Start Date: _____

Desired End Date: _____

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

Prescriber's Signature: _____

Date: _____

☐ Dispense As Written/Do Not Substitute