

## Universal 17-P Authorization Form

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

Phone: 800-514-0083 option 2 Fax: 866-374-1579

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 weeks and 6 days?  Yes  No

Previous Preterm Delivery Gestational Age: \_\_\_\_\_ weeks \_\_\_\_\_ days

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)

