

Universal 17-P Authorization Form

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

Phone: 1-800-514-0833 ext-2 Fax: 1-866-374-1579

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 16-36.6 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)

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

Yes No

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 1/2 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