PRIOR AUTHORIZATION REQUEST
Intravaginal Progesterone Products

PATIENT: Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber: Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: _____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ❑ Yes ❑ No Is this medication being prescribed by, or in consultation with, a provider of obstetrical care?
2. ❑ Yes ❑ No Is the patient on Makena (17-hydroxyprogesterone)?
3. ❑ Yes ❑ No Is the patient pregnant with singleton gestation?
4. Does the patient have a history of spontaneous preterm birth (for example, delivery of an infant LESS THAN 37 weeks of gestation)?
   - ❑ Yes → ***please answer question 5 only***
   - ❑ No → ***please answer question 6 and 7***
5. ❑ Yes ❑ No Has the patient been using progesterone no earlier than 16 weeks, 0 days and no LATER THAN 23 weeks, 6 days?
6. ❑ Yes ❑ No Does the patient have a cervical length LESS THAN 25 mm before 24 weeks of gestation?
7. ❑ Yes ❑ No Has the patient been using progesterone no earlier than 16 weeks, 0 days and no LATER THAN 23 weeks, 6 days?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____ _____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851