maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Intravaginal Progesterone

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this medication being prescribed by, or in consultation with, a provider of obstetrical care? [If no, no further questions.]	Yes	No
2	Is the patient pregnant with singleton gestation? [If no, no further questions.]	Yes	No
3	Does the patient have a history of spontaneous preterm birth (for example, delivery of an infant LESS THAN 37 weeks of gestation)? [If yes, skip to question 5.]	Yes	No
4	Does the patient have a cervical length LESS THAN 25 millimeters before 24	Yes	No

If you have any questions, call:
1-888-258-8250

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	weeks of gestation? [If no, no further questions.]		
5	Is therapy being initiated BETWEEN 16 weeks and 24 weeks of gestation and continued until 37 weeks gestation? Please provide the patient's current gestation in weeks and days: _____	Yes	No

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: 1-833-896-0656

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.

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