peach state health plan

Universal 17-P Authorization Form

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

Phone: 1-800-514-0083 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)

____

Patient/Member Name: ______________________________ DOB: ______________
Address (Street, Apt. #): ____
City/State/Zip: ____

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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

IDC-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

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

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