UnitedHealthcare Community Plan

VAGINAL PROGESTERONE
Crinone / Prochieve
PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____
Is this patient currently hospitalized? □Yes □No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:** **Frequency of Dosage:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 CODE:**

Is this member currently pregnant? Yes or No (Circle Answer)
If Yes,, what is the member's current gestational age: _____ Due Date:_____

Is the requested medication being used as a fertility treatment? Yes or No (Circle Answer)

Does the patient have a short cervix, defined as a cervical length of 25 mm or less? Yes or No (Circle Answer)
If Yes, what is the patient's cervical length? _____

Did the patient undergo a transvaginal sonographic cervical length examination between 20 weeks + 0 days and 23 weeks + 6 days gestation? Yes or No (Circle Answer)

Does the patient have a singleton gestation without major fetal anomalies? Yes or No (Circle Answer)

Does the patient have any of the following risk factors? (Check Risk Factors or None below)

- □ **Current / recent symptoms of preterm labor (regular uterine contractions resulting in cervical shortening or dilation)**
- □ **Acute cervical dilation**
- □ **Major fetal anomaly or known chromosomal abnormality**
- □ **Uterine anatomic malformation**
- □ **Chorioamnionitis (infection of the amniotic fliud)**
- □ **Twins or greater gestations**
- □ **None of these risk factors**

Will the patient be initiating therapy with the requested medication between 20 weeks + 0 days and 23 weeks + 6 days gestation? Yes or No (Circle Answer) If no, please provide duration of treatment: _____

Additional Clinical Information to Support this Request:_____
_____

Physician Signature: _____ Date: _____