17-ALPHA HYDROXY PROGESTERONE

PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date :		
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:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-9 CODE:**

- Is this a new prescription for the patient or a continuation of existing therapy?
- Does the patient have a history of previous preterm delivery, defined as a previous spontaneous birth at less than 37 weeks gestation? Gravidity: _____ Parity: _____
- What is the patient's gestational age? List gestational age: _____ weeks _____ days

  Estimated due date: _____
- What is the patient's estimated date of delivery *or* date of the first day of the last period?
  List estimated date of delivery: _____
  List date of the first day of the last period: _____

Physician Signature: _____ Date: _____

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