carolina complete health

Pharmacy Request for Prior Approval - Crinone 8% Gel

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescribing DEA #:_____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Crinone 8% Gel** 11. Boxes Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

Request for Non-Preferred Drug:

1. Is the recipient a female? ☐ Yes ☐ No

2. Is the recipient pregnant? ☐ Yes ☐ No

3. Does the recipient have a documented ultrasound of transvaginal cervical length (TVCL) less than 25mm between 17 and 24 weeks of gestation? ☐ Yes ☐ No

4. Is Crinone being used for the recipient to treat infertility? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309