carolina complete health

Pharmacy Prior Approval Request for Crinone 8% Gel

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ___

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

☐ Other _____

Clinical Information

1. Is the beneficiary 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 or equal to 25mm between 17 and 24 weeks of gestation? ☐ **Yes** ☐ **No**
4. Does the beneficiary have a diagnosis of secondary amenorrhea and has failed Crinone 4% gel? ☐ **Yes** ☐ **No**
5. Is Crinone being used for the recipient to treat infertility? ☐ **Yes** ☐ **No**

Crinone can be approved for up to 2 boxes (15 single use applicators per box) per 30 days. Crinone can be approved until end of pregnancy

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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/