WellCare
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Universal 17-P Authorization Form

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

Phone: <<CMO specific>> Fax: <<CMO Specific>>

Date of Request for Authorization: _____

Patient/Enrollee 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 weeks and 6 days? ☐ Yes ☐ No

Previous Preterm Delivery Gestational Age: _____ weeks _____ days

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)

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Patient/Enrollee Name: _____ **DOB:** _____
Address (Street, Apt. #): _____
City/State/Zip: _____

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 hydroxyprogesterone caproate? ☐ Yes ☐ No

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

ICD-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

RX: (Select one product) Must be administered by a health care professional

☐ Compounded 17P *Medical billing use:* **J1729 (Compound)** – hydroxyprogesterone caproate, 10mg]

☐ Hydroxyprogesterone caproate injection 250 mg/ mL *Medical billing use:* **J1726 (Makena branded vial, Makena Auto-injector, or generic)**

- ☐ **Single-dose**, **preservative free vial** SIG: 250mg (1.0 mL) IM to upper outer quadrant of gluteus maximus weekly
  - ☐ 18-g needles & 3 mL syringe___#
  - ☐ 21-g 1 ½-needle _____ #
- ☐ **Subcutaneous Auto-Injector** SIG: 275mg (1.1mL) SQ to back of upper arm weekly

☐ Dispense 4 doses, X____ refills

Please Ship To:

☐ Prescriber ☐ Patient

Preferred Injection Setting:

☐ Healthcare Provider Office

☐ Home Health Care agency, if approved by insurance - weekly visit with maternal/fetal assessment and Makena/17HPC administration

- ☐ Agency name: _____
- ☐ Health Plan Preferred Agency: _____

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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