Universal 17-P Authorization Form

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

☐**Absolute Total Care**	☐**BlueChoice HealthPlan**	☐**First Choice by Select Health**	☐**WellCare Health Plan, Inc.**
P: 866-433-6041 F: 866-918-4451	P: 866-902-1689 F: 800-823-5520	P: 888-559-1010 x55251 F: 866-533-5493	P: 888-588-9842 F: 866-458-9245

☐**Advicare**	☐**Molina Healthcare, Inc.**
P: 888- 781-4371 F: 888- 781-4316	P: 855- 237-6178 F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐Pregnancy Information and History

G___ T ___ P ___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes☐ No
(Home administration available if on bed rest)

☐Singleton Pregnancy ☐Multiple Pregnancy

At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No

Medication Allergies _____ ☐No known drug allergies

Other Pertinent Clinical Information:_____

_____

☐Pharmacy Information

☐Ship to patient's home address End Date of Service _____

☐Ship to provider's address End Date of Service _____

Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight

Ordering Physician's Signature: _____ Makena or 17-P Compound _____

☐Provider Information

Ordering Provider Name_____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐OB/GYN ☐Family Medicine ☐MFM/Perinatology ☐Other

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax:

_____

FOR MCO USE ONLY:

☐Approved ☐Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week