



**Crinone® (progesterone gel) and Endometrin® (progesterone vaginal insert)
Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Drug Name: _____ **Strength:** _____ **NDC:** _____

Fill Date: _____ **Fill Quantity:** _____ **Day Supply:** _____

Regimen: _____ **Refills:** _____

Pharmacy Information

Pharmacy NPI: _____ **Pharmacy Name:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Clinical Information

1. Does member have a history of previous singleton spontaneous preterm delivery (SPTD)? Yes ___ No ___
2. Current singleton pregnancy? Yes ___ No ___ Date of Ultrasound: _____
3. Gestational age of current pregnancy: _____ Date: _____
4. Estimated delivery date: _____
5. Member's cervical length: _____ mm
6. If requesting Crinone®, please provide a patient-specific, clinically significant reason why the member cannot use Endometrin®: _____

Additional Information: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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