



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/Member 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

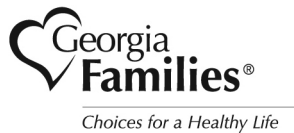
Cholestatic jaundice of pregnancy Yes No

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)



WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids*[®] members enrolled in the *Georgia Families*[®] program and women enrolled in the *Planning for Healthy Babies*[®] program.

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



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