



### 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)

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Patient/Member 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

### 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: \_\_\_\_\_

## 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

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



WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids*<sup>®</sup> members enrolled in the *Georgia Families*<sup>®</sup> program and women enrolled in the *Planning for Healthy Babies*<sup>®</sup> program.