AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Crinone 8%

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Is the beneficiary a female? Yes___ No___
2. Is the beneficiary pregnant? Yes___ No___
3. Does the beneficiary have a documented ultrasound of transvaginal cervical length (TVCL) less than or equal to 25mm between 17 and 24 weeks of gestation? Yes___ No___
4. Does the beneficiary have a diagnosis of secondary amenorrhea and has failed Crinone 4% gel? Yes___ No___
5. Is Crinone being used for the beneficiary to treat infertility? Yes___ No___

Crinone can be approved for up to 2 boxes (15 single use applicators per box) per 30 days. Crinone can be approved until end of pregnancy.

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406