



NC DHB Pharmacy Request for Prior Approval - Crinone 8% Gel

Recipient Information

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: NPI: or Atypical: 8. Prescribing DEA #: Requester Contact Information Name: Phone #: Ext:

Drug Information

9. Drug Name: Crinone 8% Gel 11. Boxes Per 30 Days: 12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other:

Clinical Information

Request for Non-Preferred Drug: 1. Is the recipient a female? Yes No 2. Is the recipient pregnant? Yes No 3. Does the recipient have a documented ultrasound of transvaginal cervical length (TVCL) less than 25mm between 17 and 24 weeks of gestation? Yes No 4. Is Crinone being used for the recipient to treat infertility? Yes No

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: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318