OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
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