UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Crinone

Beneficiary Information

1. Beneficiary Last Name: ________________________ 2. First Name: _____________________________________
3. Beneficiary ID #: ________________ 4. Beneficiary Date of Birth: ________________ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information - Name: _________________________ Phone #: ___________________ Ext. ____

Drug Information

8. Drug Name: ____________________________________ 9. Strength: ____________________ 10. Quantity Per 30 Days: ______________
11. Length of Therapy (in days): ☐ 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 recipient pregnant? ☐ **Yes** ☐ **No**
3. Does the recipient 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. Is Crinone being used for the recipient 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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593