

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
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. 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
4. 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
5. Does the beneficiary have a diagnosis of secondary amenorrhea and has failed Crinone 4% gel? Yes No
6. 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.