



Process for Prior Authorization of 17-Alpha-hydroxyprogesterone Caproate (17P)

Children's Community Health Plan/Dean Health Plan Southeast will provide 17P as a benefit for members whose member's physician has identified them as at risk for preterm delivery.

PA form for 17P is posted at www.childrenschp.com for providers to access.

Provider completes PA and faxes it to CCHP at 414-266-4726

Once received, UM/Case Management staff will review the PA and process the request within 48 hours. If the physician has indicated that a member has a history of preterm labor and delivery, the nurse case manager reviews the case and completes the PA form with a decision of approval or denial. We will request additional information as needed from the physician if needed to complete the authorization.

A decision letter will be sent to the member. A copy of the letter and the PA will be sent to the provider. A copy of the letter and PA will be faxed to the pharmacy where the 17P will be dispensed.

It will be the responsibility of the provider to call or fax in the prescription for the 17P to the pharmacy.

The medication will be sent directly to the physician's office for administration.

If a member is home bound or on bed rest, a home health referral to an in-network provider may be initiated by the physician for the 17P to be given weekly in the home setting.

A referral will be made to PNCC through Children's Community Health Plan. A PNCC coordinator will contact member to discuss the program and offer services.





Prior Authorization Form 17 Alpha-hydroxyprogesterone Caproate (17P)

Patient information

Please Print

Date:	Indicate Plan: CCHP <input type="checkbox"/> DHPSE <input type="checkbox"/>
Patient Name:	
Patient Address:	
Medicaid ID Number:	
Date of Birth:	

Criteria for approval to cover 17 alpha-hydroxyprogesterone caproate ("17P")

EDC ____
 Current gestational age ____ wks G ____ P ____
 Primary diagnosis supporting the use of 17P:
 History of prior pre-term delivery
 Other
 Please elaborate: _____

When do you plan to initiate 17P treatment?

Immediately ____
 OR at
 ____ weeks' gestation

Dose/schedule of 17P use:

17 alpha-hydroxyprogesterone caproate 250mg IM weekly until: ____
 OR, indicate other dose schedule: ____

It is expected that 17P will be administered in the office of the prescribing physician. The medication will be express mailed to the physician's office. Please provide office address and phone numbers/fax number

Physician Name:
Physician Address:
Telephone #.:
Fax Number#:

Prescriber's signature: _____
 Prescriber's DEA #: _____
 Date: _____

Fax this form to: 414-266-4726
 Please allow at least 48 hours for coverage decisions.

HEALTH PLAN USE ONLY

<input type="checkbox"/> Approved	<input type="checkbox"/> Approved with Modifications	<input type="checkbox"/> Denied	<input type="checkbox"/> Written Treatment Plan Required
Processed by: _____		Date: _____	
Comments: _____ _____ _____			
Auth: _____			