WellCare
Beyond Healthcare. A Better You.

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 pregnant? ☐ Yes ☐ No
2. Does the beneficiary have a documented ultrasound of transvaginal cervical length (TVCL) less than or equal to 25mm between 17 and 24 weeks of gestation? ☐ Yes ☐ No
3. Does the beneficiary have a diagnosis of secondary amenorrhea and has failed Crinone 4% gel? ☐ 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.

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.

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

Fax this form to: 1-800-678-3189
Pharmacy PA Call Center: 1-866-799-5318