

17 Alpha-Hydroxyprogesterone Injection (17-P)
 Prior Authorization Form



ROCKY MOUNTAIN
HEALTH PLANS®

We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

Pharmacy Name: **Apothecary Shop of Deer Valley**
 Pharmacy Phone: **877-546-5779 (877-LINKSRX)**
 Pharmacy Fax: **877-546-5780**

Drug will be shipped directly to the prescribing physician labeled specifically for the RMHP Member.

Complete the Clinical Assessment:

STEP 2	Clinical Consideration	<input type="checkbox"/> Patient with multiple preterm deliveries (before 37 weeks gestation) How many preterm deliveries: _____ Patients with any of the following conditions will not be candidates for 17-P therapy. Please indicate if the patient has any of the following: <input type="checkbox"/> Progesterone treatment during current therapy <input type="checkbox"/> Multifetal gestation <input type="checkbox"/> Heparin treatment during current therapy <input type="checkbox"/> Fetal anomaly <input type="checkbox"/> Hypertension requiring medication <input type="checkbox"/> Seizure disorder.
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required): Please attach a copy of the prescription or provide ALL of the information below: Compounded 17 Alpha-Hydroxyprogesterone Strength _____ Sig _____ Qty _____ Refills _____ Please attach all relevant medical records and test results. Incomplete forms will not be processed.

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3	_____	_____
	Prescriber Signature	Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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