State of Oklahoma
SoonerCare
Crinone® (progesterone gel) and Endometrin® (progesterone vaginal insert) Prior Authorization Form

SoonerSelect | aetna

Member Name: ______________________ ***Date of Birth:*** ____________ ***Member ID#:*** ________________

Drug Information

Drug Name: ____________________ ***Strength:*** ___________ ***NDC:*** _______________________

Fill Date: ________________ ***Fill Quantity:*** _____________ ***Day Supply:*** ________________

Regimen: ____________________________ ***Refills:*** ______

Pharmacy Information

Pharmacy NPI: ___________________________ ***Pharmacy Name:*** _______________________________

Pharmacy Phone: ________________________ ***Pharmacy Fax:*** _________________________________

Prescriber Information

Prescriber NPI: ____________________ ***Prescriber Name:*** _______________________________________

Prescriber Phone: ______________ ***Prescriber Fax:*** _________________ ***Specialty:*** _______________

Clinical Information

1. Does member have a history of previous singleton spontaneous preterm delivery (SPTD)? Yes____ No____
2. Current singleton pregnancy? Yes____ No____ Date of Ultrasound: ______________
3. Gestational age of current pregnancy: ________________ Date: __________________
4. Estimated delivery date: _____________________
5. Member's cervical length: _______________mm
6. If requesting Crinone®, please provide a patient-specific, clinically significant reason why the member cannot use Endometrin®: ____

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Additional Information: ____

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Prescriber Signature: _________________________________ **Date:** _______________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.

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