Patient name: ___________________________ Medicaid ID #: ___________________________
Prescriber Name: __________________ Prescriber NPI#: ___________ Contact person: _______________
Prescriber Phone#: __________________ Extension/Option: ______________ Fax#: _______________
Pharmacy: ___________________________ Pharmacy Phone#: ______________ Pharmacy Fax #: ______________
Requested Medication: ___________________________ Strength: ________ Frequency/Day: __________

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:
- Prescribed for the prevention of preterm labor for patients with prior history of preterm delivery (less than or equal to 36 weeks, 6 days, per the American Academy of Pediatrics).
- Must be prescribed by or consultation with an OB GYN.
- Therapy initiated between weeks 16-23 of gestation.
- The patient must not be in active labor at the time of administration.
- If the compounded product is requested the pharmacy provider must be certified by Utah Medicaid as compliant with USP Chapter 797 standards for sterile preparation of the injection. Please contact Utah Medicaid for a current list of certified pharmacies.

AUTHORIZATION:
For duration of the pregnancy

RE-AUTHORIZATION:
Same as initial

08/24/2017

https://medicaid.utah.gov/pharmacy/