Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Crinone 8%

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Crinone** 2. Strength: **8%** 3. Quantity per 30 Days: _____**(Max 2 boxes)**
4. 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 member a female? ☐ **Yes** ☐ **No**
2. Is the member pregnant? ☐ **Yes** ☐ **No**
3. Does the member have a documented ultrasound of transvaginal cervical length (TVCL) less than or equal to 25mm between 17 and 24 weeks of gestation? ☐ **Yes** ☐ **No**
4. Does the member have a diagnosis of secondary amenorrhea and has failed Crinone 4% gel? ☐ **Yes** ☐ **No**
5. Is Crinone being used for the member 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.

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

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.