

17-P Authorization Information

Please **fax** this form to Attention: Prenatal Department,
Select Health of South Carolina at **866.533.5493**
If you have questions, please call Prenatal Outreach at 888.559.1010

Provider Information

Date: _____

Provider Name _____ Tax ID # _____
Address, City, State Zip _____
Phone _____ Fax _____ NPI #: _____

Member Information

Member Name _____ Medicaid ID # _____
Address, City, State Zip _____
Date of Birth _____ Phone _____

Pregnancy Information & History

Gravida _____ Para _____ Abortions: Spontaneous _____ Induced _____ Three consecutive abortions Yes No
Pre-term _____ Living _____ EDC _____ Bedrest Yes No (Home administration of 17-P is available if patient is on bedrest.)

17-P Criteria and Pharmacy Information

Please check appropriate boxes for this member:

Women eligible for 17-P should meet the following criteria:

- Have a history of a previous singleton preterm birth between 20 and 36 weeks (spontaneous and no identifiable cause)
- Have a current singleton pregnancy

Pharmacy:

- Ship to patient's home End date of service: _____
- Ship to provider End date of service: _____

Physician Authorizing Signature:

Please fax PRESCRIPTION
to Boothwyn Pharmacy:
Fax 610.485.9223
Phone 610.485.1130

This section is for internal use only

17-P Authorization # _____

Covering dates of service _____ to _____

