SOUTH CAROLINA
Healthy Connections
MEDICAID

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MEDICAID BULLETIN

Phys
Pharm
Hosp
MC

TO: Providers Indicated

SUBJECT: Coverage of Hydroxyprogesterone Caproate Injection

Effective immediately, the South Carolina Department of Health and Human Services (SCDHHS) will cover both Makena® and compounded hydroxyprogesterone caproate without prior authorization. SCDHHS will provide reimbursement directly to pharmacy providers for these products ordered by a prescriber. SCDHHS will also directly reimburse physicians for these products when purchased and administered through the "buy and bill" process. For information on reimbursement, coding and rates, see www.scdhhs.gov. Coverage is allowed only for women with a singleton pregnancy with a history of singleton spontaneous preterm birth. Coverage is available from 16 through 36 weeks gestation if treatment begins between 16 and 20 weeks gestation. Other risk factors for preterm delivery do not qualify for coverage by SCDHHS. While prior authorization is not required, prescribers must maintain documentation in each patient's medical record for review by SCDHHS.

This bulletin applies to services provided to beneficiaries who are enrolled in fee-for-service Medicaid or a Medical Home Network (MHN). Claims for participants enrolled in either a Medical Homes Network or the fee-for-service program should be billed directly to Medicaid. If you have any questions regarding this policy, please contact the Provider Service Center at (888) 289-0709.

Medicaid Managed Care Organizations (MCOs) will use the form attached to this bulletin for Prior Authorization Requests for both Makena® and compounded hydroxyprogesterone caproate with the Physician indicating the requested product next to their signature.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid Program.

/s/
Anthony E. Keck
Director

Attachment

Universal 17-P Authorization Form

***Fax the COMPLETED form OR call the plan with the requested information.**

☐**Absolute Total Care**	☐**BlueChoice HealthPlan**	☐**First Choice by Select Health**	☐**WellCare Health Plan, Inc.**
P: 803-933-3689 F: 866-918-4451	P: 866-902-1689 F: 800-823-5520	P: 888-559-1010 x55251 F: 866-533-5493	P: 888-588-9842 F: 866-458-9245

☐**Advicare**	☐**Molina Healthcare, Inc.**
P: 888- 781-4371 F: 888- 781-4316	P: 855- 237-6178 F: 855- 571-3011

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐Pregnancy Information and History

G___ T ___ P ___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐Yes ☐No Experiencing Preterm Labor ☐Yes☐ No
(Home administration available if on bed rest)

☐Singleton Pregnancy ☐Multiple Pregnancy

At least 16 weeks gestation ☐Yes ☐No** Major Fetal or Uterine Anomaly ☐Yes ☐No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐Yes ☐No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐Yes ☐No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐Yes ☐No

Medication Allergies _____ ☐No known drug allergies

Other Pertinent Clinical Information:_____

_____

☐Pharmacy Information

☐Ship to patient's home address End Date of Service _____

☐Ship to provider's address End Date of Service _____

Shipping Preference: ☐Regular Mail ☐Ground ☐Overnight

Ordering Physician's Signature: _____ Makena or 17-P Compound _____

☐Provider Information

Ordering Provider Name_____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐OB/GYN ☐Family Medicine ☐MFM/Perinatology ☐Other

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax:

_____

FOR MCO USE ONLY:

☐Approved ☐Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

** Prescription may be written prior to 16 weeks, but the vial shipment may be withheld by the pharmacy until the 15th week