Ohio Department of Medicaid

PREGNANCY RISK ASSESSMENT COMMUNICATION (PRAF)

DO NOT USE the Makena Care Connection form for Medicaid patients

Practice Name:			Date of Service *(mm/dd/yyyy)*:
Practice Address:	City:	State:	Zip Code:
Patient 12-digit Medicaid ID *(to maintain Medicaid)* or Managed care ID: _____	Patient Social Security Number *(all 9 digits if using Managed Care ID)*: _____		
Patient First Name:	Last Name:	Middle Initial:	
Needed by county for pregnancy notification Estimated date of confinement *(date baby is due)* _____	Gestational Weeks: _____ Gestational Days: _____	Date Gestational Age Recorded: _____	
Patient Address:		Apartment Number:	
City:	County:	State:	Zip Code:
Date of Birth *(mm/dd/yyyy)*:	Phone: ☐ Cell Phone	Alternate Phone: ☐ Cell Phone	
Primary language *(if not English)*:	Patient Email:		
Provider Phone Number:	Provider Email Address:	Provider Fax Number:	

The name of the person at my site who should be contacted with updates/questions about this patient/form is:

☐ My practice is affiliated with the Ohio Perinatal Quality Collaborative (OPQC)

☐ I would like my patient's managed care plan, home health, &/or pharmacy to communicate with my office regarding any urgent needs identified below. **Please do not disclose any SUD information which is protected by 42 C.F.R. Part 2"**

☐ Tobacco Counseling/Treatment

☐ Referral to Ohio Department of Health Home Visiting Services

For Medicaid Application Assistance call 1-844-640-OHIO; for questions about Medicaid Programs, covered services or managed care call 1-800-324-8680

☐ Behavioral Health Linkage *indicate reason(s)*

☐ depression ☐ bipolar disorder

☐ anxiety ☐ other _____

Current Gestational Diabetes Mellitus (GDM) Diagnosis

☐ Yes ☐ No ☐ Not yet Screened ☐ Unknown

Previous diagnosis of GDM during Pregnancy

☐ Yes ☐ No ☐ Unknown

☐ Transportation ☐ No needs Identified

If you encounter difficulties in filling out this form or having patient needs met, please email Progesterone_PIP@medicaid.ohio.gov with "PIP Form" or "Barriers" in the subject line.

☐ Not a progesterone candidate

Progesterone Candidate

☐ Yes *(gestational age is or will be between 16 & 24 weeks, this is a singleton gestation, the patient had a previous singleton preterm birth prior to 37 completed gestational weeks that was related to spontaneous preterm labor, preterm ruptured membranes &/or cervical insufficiency) spontaneous preterm labor, preterm ruptured membranes &/or cervical insufficiency)*

Due to:

☐ Prior spontaneous singleton preterm birth

☐ Short cervix (<20mm)

Date progesterone 1st received/scheduled to receive _____

Form	☐ Brand	☐ Generic Compounded
Route	☐ Vaginal	☐ Injected
Location	☐ Office	☐ Home

Date next dose due *(if injection)* _____

Form	☐ Brand	☐ Generic
Route	☐ Vaginal	☐ Injected
Location	☐ Office	☐ Home

To learn more on how to submit PRAFs via the web-based NurtureOhio site please visit: http://medicaid.ohio.gov/Provider/PRAF

Patient 12-digit Medicaid ID or Managed care ID *(in case pages are separated)*	First & Last Name

Rx: 17-hydroxyprogesterone caproate injection

☐ Multi-dose vial (5 mL) ☐ Single-dose vial (1 mL) ☐ Auto-injector (1.1 mL)

☐ Inject 250 mg (1 mL) IM once weekly (weeks 16 - 36 of pregnancy)

☐ Auto-inject 275 mg (1.1 mL) SQ once weekly (weeks 16 - 36 of pregnancy)

Scheduled start date of 17- hydroxyprogesterone caproate therapy

(mm/dd/yyyy): _____ Quantity: _____ Refills: _____

Included with each dose & refills

☐ 18-g needle & 3 mL syringe number
(for drawing out of multi-dose vial)

☐ 21-g, 11/2"needle number

ICD-10 _____

Rx: Vaginal progesterone

Quantity: _____ Refills: _____

☐ 200 mg Generic micronized progesterone 1 capsule OR pill placed in vagina QHS

☐ 200 mg Prometrium® 1 capsule OR pill placed in vagina QHS

☐ 200 mg Compounded vaginal progesterone suppository 1 QHS

☐ 200 mg First Progesterone 1 vaginal suppository QHS

☐ 90 mg 8% Crinone® gel placed vaginally QHS

☐ 90 mg 8% Prochieve® gel placed vaginally QHS

Please Ship:

17-Hydroxyprogesterone Caproate to

☐ Prescriber's office

☐ Patient, to be injected by home health agency

Home Health Care Company *(Choose only one)*

☐ Alere/Optum – **FAX Number** (800) 867-2872 | **PH Number** (800) 999-2415

☐ OptionCare – **FAX Number** (877) 865-9133 | **PH Number** (888) 304-1800

☐ Other Specify _____

Prescribers Phone:	Prescribers Email:

**By signing below, the physician is providing the pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication*

Prescriber's Name:	Credentials:	NPI/CPT:
Prescriber's Agent *(if applicable)*:		
Prescriber's Signature:	Date *(mm/dd/yyyy)*:	DAW *(initial here)*:

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