Ohio Department of Medicaid

Pregnancy Risk Assessment Communication (PRAF)

***DO NOT USE** the Makena Care Connection form for Medicaid patients*

Items with an asterisk (*) are required to process this form

*Practice Name		*Date of Service *(MM/DD/YYYY)*	
*Provider Billing NPI Number		*Rendering Provider MCD ID Number	
Practice Address	City	State	Zip Code
*Patient 12-digit Medicaid ID *(to maintain Medicaid)*		*Patient Social Security Number *(all 9 digits)*	
Patient First Name	Last Name		Middle Initial
*Estimated date of confinement	* Gestational Weeks ____ * Gestational Days ____ * Date Gestational Age Recorded ____		*Number of Fetuses
Patient Address			Apartment Number
City	County	State	Zip Code
*Date of Birth	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

☐ I would like my patient's managed care plan, home health, &/or pharmacy to communicate with my office regarding any urgent needs identified below.

Medical Needs

☐ No needs Identified

Gestational Diabetes Mellitus (GDM) Diagnosis

☐ Yes ☐ No ☐ Not yet Screened ☐ Unknown

Previous diagnosis of GDM during Pregnancy

☐ Yes ☐ No ☐ Unknown

Behavioral Health Diagnosis (indicate reason(s)-please check all that apply)

☐ Anxiety ☐ Bipolar disorder ☐ Depression ☐ Substance Use Disorder

Substance Use Disorder Needs (please check all that apply):

- ☐ Alcohol Use Disorder Counseling/Treatment
- ☐ Opioid Use Disorder (please check one of the following):
  - ☐ Interested in and Referred Medication-Assisted Therapy (MAT) for Opiate Use Disorder (e.g. Methadone, Buprenorphine, Subutex)
  - ☐ Currently receiving Medication-Assisted Therapy (MAT) for Opiate Use Disorder
  - ☐ Patient declined MAT services
- ☐ Opioid Use Disorder in remission (please check one of the following):
  - ☐ Interested in and Referred Medication-Assisted Therapy (MAT) for Opiate Use Disorder (e.g. Methadone, Buprenorphine, Subutex)
  - ☐ Currently receiving Medication-Assisted Therapy (MAT) for Opiate Use Disorder
  - ☐ Patient declined MAT services
- ☐ Other Substance Use Disorders ____

Social Needs

☐ No needs Identified

Tobacco Counseling/Treatment (please check all that apply)

- ☐ Patient is currently smoking or using tobacco products
- ☐ Patient is willing to quit smoking or using tobacco products during pregnancy
- ☐ Patient requested MCP referral to smoking/tobacco cessation resources
- ☐ Practice already referred member to smoking/tobacco cessation resources

☐ Transportation

☐ Referral to Ohio Department of Health Home Visiting Services

☐ Referral to Ohio Department of Health Women, Infant & Children (WIC) Program

☐ other (specify here) *:* ____

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

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			Date next dose due *(if injection)*		
Form	☐ Brand	☐ Generic Compounded	Form	☐ Brand	☐ Generic
Route	☐ Vaginal	☐ Injected	Route	☐ Vaginal	☐ Injected
Location	☐ Office	☐ Home	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 Name	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

Date *(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	Home Health Care Company *(Choose only one)*
17-Hydroxyprogesterone Caproate to	☐ Alere/Optum – FAX Number (800) 867-2872 | PH Number (800) 999-2415
☐ Prescriber's office	☐ Option Care – FAX Number (877) 865-9133 | PH Number (888) 304-1800
☐ Patient, to be injected by home health agency	☐ 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)*

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