Through research and consultation with health care professionals, the Division of Medicaid (DOM) recognizes that progesterone is a nationally recognized mode of therapy for the maintenance of pregnancy. Such therapy is important in reducing costs associated with negative outcomes and improving the quality of care for pregnant women.

To support the prevention of pre-term births, the Division of Medicaid will cover intramuscular injections of 17 Alpha-Hydroxyprogesterone injection (17-P) weekly from 16 – 36 weeks gestation when **one** of the following indications are present.

Indications

1. Patient with a history of spontaneous prior pre-term birth in a singleton pregnancy, with or without shortened cervix, that was not an indicated delivery for obstetric, infectious or medical disorder/pre-eclampsia reason(s).

OR

2. Patient with a singleton gestation and a shortened cervix as demonstrated by vaginal ultrasound ($\geq$ 5 mm but $\leq$ 25 mm 18 – 34 weeks).

The therapy should be started by 21 weeks gestation for best results, but can be initiated later in gestation if the patient is identified as a candidate at a later time. No benefit is gained if the mode of therapy is initiated at or after 34 weeks of gestation.

Prescribing providers must document the beneficiary's desire to take 17-P injections and to be compliant with the treatment plan. In addition, the providers are responsible for ensuring that the beneficiary is taught the signs and symptoms of pre-term labor and what to do if she experiences any of the symptoms.

Contraindications

If the beneficiary has one of the following contraindications, benefits will not be provided for the injection of 17-P.

1. Prior pre-term delivery/birth indicated or occurred in association with infection, obstetric and/or medical disorder causation.

2. Multiple gestation unless cervix is shortened.

3. Ruptured membranes

4. Evidence of chorioamnionitis

5. Cervical length < 5mm

The drug must be administered in a physician office or clinic. The provider must bill Medicaid on a CMS 1500 claim form under the physician's Medicaid provider number (individual or group) using HCPCS code ~~J3450~~ J3490 along with the National Drug Code (NDC). In addition, the provider must complete the attached Certificate of Medical Necessity and send to the fiscal agent's Medical Review Department.

Vaginal progesterone 200 mg. nightly from 16 – 36 weeks gestation is also another recognized mode of therapy for the same indications. This drug may be accessed for beneficiaries through DOM's Pharmacy program.

Certificate of Medical Necessity
17 Alpha-Hydroxyprogesterone (17-P)
Mississippi Medicaid

Patient Information:
Patient Name: _____ Date of Birth _____
Medicaid # _____ Phone # _____

Physician Information:
Physician Name _____ Physician Medicaid ID # _____
Specialty _____
Address _____
City _____ State _____ Zip _____
Phone ( ) _____ Fax ( ) _____

Compliance with all of the criteria listed in Policy section 56.05 is a condition for payment for this drug by Mississippi Medicaid. To assist the fiscal agent in determining whether the drug is covered, the following questions must be completed by the physician and submitted to the fiscal agent's Medical Review Unit.

What is the current gestational age in weeks?_____ Expected date of delivery?_____

YES	NO	
☐	☐	Does the patient have a history of spontaneous prior pre-term birth in a singleton pregnancy, with or without shortened cervix, that was not an indicated delivery for obstetric, infectious or medical disorder/pre-eclampsia reason(s)? If yes, provide the gestational age(s) in weeks of the prior spontaneous preterm birth(s): _____
		OR
☐	☐	Does the patient have a singleton gestation and a shortened cervix as demonstrated by vaginal ultrasound ($\geq$ 5 mm but $\leq$ 25 mm 18 – 34 weeks)?
☐	☐	Has the patient been taught the signs and symptoms of pre-term labor and what to do if she experiences any of the signs and symptoms?
☐	☐	Has the patient agreed to take 17-P injections and agreed to be compliant with the treatment program?
☐	☐	Does the patient have any of the contraindications listed in the Division of Medicaid's policy section 56.05? If yes, identify: _____

Physician Signature: _____ Date: _____
(By signature, the physician confirms the information above is accurate and verifiable in the patient records.)

Mail or fax the Certificate of Medical Necessity to the fiscal agent:

ACS
Attn: Medical Review
P. O. Box 23080
Jackson, MS 39225

OR

Fax #: 601–206–3119
Attention: Medical Review