

MAKENA (hydroxyprogesterone caproate) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Makena (hydroxyprogesterone caproate)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # pages: _____	
Name of office contact:		Prescriber name:	
Contact's phone number:		Specialty:	
LTC facility contact/phone:		State license #:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	<input type="checkbox"/> hydroxyprogesterone caproate injection (non-preferred)	<input type="checkbox"/> Makena 250 mg/ml (1 ml) single-dose vial*
	<input type="checkbox"/> Makena 275 mg/1.1 ml autoinjector*	<input type="checkbox"/> Makena 250 mg/ml (5 ml) multi-dose vial*
	<input type="checkbox"/> _____	<i>*preferred with clinical prior authorization required</i>
Dose/directions:	Quantity:	Refills:
Diagnosis (submit documentation):	<input type="checkbox"/> pregnancy with history of pre-term labor <input type="checkbox"/> other: _____	
Dx codes (required):	Start date of therapy: _____ / _____ / 20_____	
1. Makena is included in the DHS Specialty Pharmacy Drug Program (SPDP). What specialty pharmacy will be used?	<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreen's Specialty Pharmacy	
2. Is the beneficiary currently pregnant with a single fetus?	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No	
3. What is the current gestational age?	Weeks: _____ Days: _____	
4. Does the beneficiary have a documented history of a prior spontaneous preterm singleton birth (defined as prior to 37 weeks' gestation)?	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No	
5. Does the beneficiary have any of the following contraindications to the use of Makena? <u>Check all that apply.</u>	<input type="checkbox"/> Yes <i>If yes, submit supporting documentation.</i> <input type="checkbox"/> No	
6. Does the beneficiary have any of the following conditions? <u>Check all that apply.</u>	<input type="checkbox"/> Yes <i>If yes, submit supporting documentation.</i> <input type="checkbox"/> No	
7. For non-preferred hydroxyprogesterone caproate (generic Makena): Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent – Makena ?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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