pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

MAKENA and HYDROXYPROGESTERONE CAPROATE PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Progestational Agents** 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.

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:	Dosage form (auto-injector, vial, etc.)
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:	☐ pregnancy with history of pre-term labor	☐ other: _____	
Dx codes (*required*):	Start date of therapy: _____ / _____ / 20_____		
	Current gestational age: weeks: _____ days: _____		

Is the beneficiary currently pregnant with a single fetus?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have a documented history of a prior spontaneous preterm singleton birth (defined as prior to 37 weeks' gestation)?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have any of the following contraindications to the use of Makena? *Check all that apply.* ☐current or history of thrombosis or thromboembolic disorders ☐history of or current known or suspected breast cancer or other hormone-sensitive cancer ☐undiagnosed abnormal vaginal bleeding unrelated to pregnancy ☐cholestatic jaundice of pregnancy ☐benign or malignant liver tumors or active liver disease ☐uncontrolled hypertension	☐Yes ☐No *Submit documentation.*
For a non-preferred hydroxyprogesterone caproate product: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred hydroxyprogesterone caproate products in this class approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit documentation.* ☐No

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

Prescriber Signature:	Date: