Prior Authorization Form - Makena

Please note: All Makena prior authorizations are worked by the Superior Pharmacy Team.

Phone: 1-800-218-7453, ext. 22080 | Fax: 1-866-683-5631

Select a billing option below:

❑ **Makena will be billed via the pharmacy benefit.**
If billed through pharmacy benefit please include:
Specialty Pharmacy Name: _____
Specialty Pharmacy Phone: _____
Today's Date: _____ Date Medication is required: _____

❑ **Makena will be billed via buy and bill.**

Patient Name:	Physician Name:
Address:	State Lic #: DEA #:
City: State: Zip:	NPI #: UPIN #:
Home Phone: ( ) -	Practice Name/Hospital:
Alt Phone: ( ) -	Practice Address:
Cell Phone: ( ) -	
Date of Birth: _____/_____/_____	City: State: Zip:
	Physician's Phone: ( ) -
Allergies:	Physician's Fax: ( ) -
Member ID:	Nurse/Key Office Contact: Direct Ext:

Clinical Information

1. Is this a single fetal or multi-fetal pregnancy? _____
2. What is the current gestational age of this pregnancy? _____
   Date Recorded: _____/_____/_____
3. What is the Estimated Date of Delivery (EDD)? _____
4. Does patient have a history of singleton spontaneous preterm birth? ❑ Yes ❑ No
5. Is there history of or current thrombosis or thrombolembolic disease? ❑ Yes ❑ No
6. Is there known/suspected breast or hormone sensitive cancer or history of these cancers? ❑ Yes ❑ No
7. Does patient have undiagnosed vaginal bleeding not related to pregnancy? ❑ Yes ❑ No
8. Does patient have cholestatic jaundice of pregnancy? ❑ Yes ❑ No
9. Is there evidence of benign or malignant liver tumor or active liver disease? ❑ Yes ❑ No
10. Does the patient have uncontrolled hypertension? ❑ Yes ❑ No
11. Is the patient currently receiving Makena or hydroxyprogresterone caproate? ❑ Yes ❑ No
    If yes, what was the start date? _____/_____/_____

Appropriate and complete clinical information, including the prenatal record, is needed to review your request and validate the information marked above.
If authorization is approved, please provide a prescription to the specialty pharmacy directly for processing.

MEDICATION	STRENGTH	DIRECTIONS

Makena requests may be submitted for approval just prior to 16 weeks, 0 days gestation to allow time for prior authorization processing. This is especially helpful for Makena billed through the pharmacy benefit to also allow shipping from the pharmacy. Please do not submit Makena requests before 13 weeks gestation.

Physician Signature: _____ **Date**: _____/_____/_____