

# 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:
Allergies:	Physician's Phone: ( ) -		
Member ID:	Physician's Fax: ( ) -		
	Nurse/Key Office Contact:	Direct Ext:	

**Clinical Information**

- Is this a single fetal or multi-fetal pregnancy? \_\_\_\_\_
- What is the current gestational age of this pregnancy? \_\_\_\_\_  
Date Recorded: \_\_\_\_/\_\_\_\_/\_\_\_\_
- What is the Estimated Date of Delivery (EDD)? \_\_\_\_\_
- Does patient have a history of singleton spontaneous preterm birth?  Yes  No
- Is there history of or current thrombosis or thromboembolic disease?  Yes  No
- Is there known/suspected breast or hormone sensitive cancer or history of these cancers?  Yes  No
- Does patient have undiagnosed vaginal bleeding not related to pregnancy?  Yes  No
- Does patient have cholestatic jaundice of pregnancy?  Yes  No
- Is there evidence of benign or malignant liver tumor or active liver disease?  Yes  No
- Does the patient have uncontrolled hypertension?  Yes  No
- Is the patient currently receiving Makena or hydroxyprogesterone 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the name addressee and may contain material that is confidential, privileged, proprietary, or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the name addressee, except by express authority of sender to the name addressee.