

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.

Makena will be billed via buy and bill.

If billed through pharmacy benefit please include:

Specialty Pharmacy Name: _____

Specialty Pharmacy Phone: _____

Today's Date: _____ Date Medication is required: _____

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: () -		
County:	Physician's Fax: () -		
	Nurse/Key Office Contact:		Direct Ext:

Insurance Information (Please copy and attach the front and back of insurance and prescription drug card.)

Prescription Card- Name of Insurer: ID #: BIN: PCN: Group:

Primary Insurance- Subscriber: ID #: Name of Insurer: Tel #:

Secondary Insurance- Subscriber: ID #: Name of Insurer: Tel #:

Specialty:

Address:

Diagnosis (Required)

Single fetal pregnancy Multi-fetal pregnancy

What is the current gestational age of this pregnancy? _____

Patient Evaluation

- Does patient have a history of singleton spontaneous birth < 37 weeks? 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

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	QUANTITY	REFILLS

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.

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.