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: ( ) -
County:	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

1. Does patient have a history of singleton spontaneous birth < 37 weeks?	❑ Yes	❑ No
2. Is there history of or current thrombosis or thrombolembolic disease?	❑ Yes	❑ No
3. Is there known/suspected breast or hormone sensitive cancer or history of these cancers?	❑ Yes	❑ No
4. Does patient have undiagnosed vaginal bleeding not related to pregnancy?	❑ Yes	❑ No
5. Does patient have cholestatic jaundice of pregnancy?	❑ Yes	❑ No
6. Is there evidence of benign or malignant liver tumor or active liver disease?	❑ Yes	❑ No
7. 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**: _____/_____/_____