MAKENA (HYDROXYPROGESTERONE CAPROATE) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:		Fax:

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

CLINICAL INFORMATION

Medication requested:

☐ hydroxyprogesterone caproate injection (non-preferred)
☐ Makena 275 mg/1.1 ml autoinjector*
☐ _____
☐ Makena 250 mg/ml (1 ml) single-dose vial*
☐ Makena 250 mg/ml (5 ml) multi-dose vial*

*preferred with clinical prior authorization required

Dose/directions:		Quantity:	Refills:
Diagnosis (submit documentation): ☐ pregnancy with history of pre-term labor ☐ other: _____			
DX codes (required):	Start date of therapy: _____ / _____ / 20_____		
1. Is the patient currently pregnant with a single fetus?	☐ Yes ☐ No	*Submit supporting documentation.*	
2. What is the current gestational age? Weeks: _____ Days: _____			
3. Does the patient have a documented history of a prior spontaneous pre-term singleton birth (defined as prior to 37 weeks' gestation)?	☐ Yes ☐ No	*Submit supporting documentation.*	
4. Does the patient 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	*If yes, submit supporting documentation.*	
5. Does the patient have any of the following conditions?. Check all that apply. ☐ history of, or plans for, a cervical cerclage ☐ known fetal anomaly ☐ history of seizure disorder	☐ Yes ☐ No	*If yes, submit supporting documentation.*	
6. For non-preferred hydroxyprogesterone caproate (generic Makena): Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agent – **Makena**?	☐ Yes ☐ No	*Submit documentation.*	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: