AmeriHealth

Today's date: _____ **Date medication needed:** _____

Prior Authorization Form - Makena™ /17 Alpha-Hydroxyprogesterone Caproate

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: ☐ **Makena™** ☐ **Preservative-free Compound** (17 alpha-hydroxyprogesterone caproate)

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of Birth	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) When is the patient scheduled to start either Makena or 17 alpha-hydroxyprogesterone caproate?

_____

3) Patient medical information

a.	Is this a singleton pregnancy?	☐ Yes	☐ No
b.	Is the patient currently in preterm labor with this singleton pregnancy?	☐ Yes	☐ No
c.	Are there any risk factors for preterm birth in this patient (e.g., pregnancy-induced hypertension)?	☐ Yes	☐ No
d.	Does the patient have a documented history of singleton spontaneous preterm birth (occurring less than 37 weeks gestation)? If yes, please fax this documentation along with this form.	☐ Yes	☐ No
e.	Has the patient had an ultrasound that confirmed gestational age between 16 weeks and 37 weeks? If yes, please fax the ultrasound results along with this form.	☐ Yes	☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

4) Prescription Information:

Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ Every _____ day(s)/ week(s)/ month(s)

Physician's Signature: _____

Please fax this completed form to 215-761-9580.