

Today's date: \_\_\_\_\_

Intended date of injection: \_\_\_\_\_

**Prior Authorization Form – Makena® /17 Alpha-Hydroxyprogesterone Caproate**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED.**

Select one:  Makena® single-dose vial  Makena® multi-dose vial  Makena® SC autoinjector  
 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

**This drug will be delivered to the requesting physician.**

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

1) **Diagnosis for drug requested (must include ICD-10):** \_\_\_\_\_

**2) Patient medical information**

- a. Is this a singleton pregnancy, confirmed by ultrasound? If yes, please fax the ultrasound results along with this form.  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 between 20 weeks and 37 weeks gestation)? If yes, please fax this documentation along with this form.  Yes  No
- e. Will the weekly injections be administered between 16 weeks 0 days and 36 weeks 6 days of gestation?  Yes  No

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3) 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.**