

Fax Referral To:

814-283-2211

www.vsprx.com



Makena Enrollment Form

Ship to:

Office

Other:

855-265-8008

PATIENT INFORMATION

PRESCRIBER INFORMATION

<i>(Complete the following or send patient demographics)</i>				Prescriber Name:			
Patient:				State License #:		UPIN:	
Address:				DEA #:		NPI #:	
City, State:				Group or Hospital:			
Home				Address:			
Cell Phone:				City, State Zip:			
Allergies:				Phone:		Fax:	
Date of Birth:		Gender:		Contact Person:			Phone:
Insurance Carrier Name		ID#		Group#		PCN#	Relationship to Policyholder

DIAGNOSIS INFORMATION

History of Singleton Preterm Birth  Other \_\_\_\_\_ ICD - 10 \_\_\_\_\_

PRESCRIPTION STATUS

New  Reauthorization  Restart

PRESCRIPTION and PRIOR AUTHORIZATION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	FREQUENCY	QUANTITY	REFILLS
<input type="checkbox"/> Makena	<input type="checkbox"/> 250mg/ml	Inject 1ml (250mg) intramuscularly	<input type="checkbox"/> every 7 days <input type="checkbox"/> _____	<input type="checkbox"/> (#4) 1ml vials <input type="checkbox"/> (#1) 5ml vial	

Patient has had prior preterm birth  Yes, Specify \_\_\_\_\_  No

Current gestational age \_\_\_\_\_ weeks \_\_\_\_\_ days

Is this medication to be used for a singleton pregnancy?  Yes  No, explain \_\_\_\_\_

Makena must be started on or after 16 weeks gestation but before 21 weeks  Agree  Disagree

Makena must be stopped at 36 weeks, 6 days gestation or delivery, whichever comes first  Agree  Disagree

Start date of next injection \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gravity \_\_\_\_\_ Parity \_\_\_\_\_ EDD \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ LMP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Supplies Needed  1.5qt sharps  Alcohol Swabs  18g 3ml 1.5" syringes (for withdrawing)  21g 1.5" needles (for injecting medication)

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

Physician Signature	Date	This prescription will be filled generically unless prescriber writes "DAW" in the box to the right	<input type="text"/>
			<input type="text"/>