



Makena Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs _____ kg _____
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Diagnosis

009.212 Supervision of pregnancy with history of preterm labor, second trimester Z87.51 Personal history of preterm labor
 009.213 Supervision of pregnancy with history of preterm labor, third trimester Other: _____
 009.219 Supervision of pregnancy with history of preterm labor, unspecified trimester

Clinical Information

Please attach clinical office notes and ultrasound report, if available, to expedite the prior authorization

Patient has had preterm birth Yes, Specify gestation _____ No
 Current gestational age _____ weeks _____ days Date recorded: ____/____/____
 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, explain _____
 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 ____/____/____

Prescription

Medication	Directions	Frequency	Quantity	Refills
<input type="checkbox"/> Makena 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	
<input type="checkbox"/> Makena 275mg/1.1ml auto-injector	Inject 1.1ml (275mg) subcutaneously	<input type="checkbox"/> every 7 days <input type="checkbox"/> _____	<input type="checkbox"/> #4 auto-injectors	

Supplies

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

Is patient new to this therapy: YES NO | Ship to: Patient Office Other

Prescriber Data

Prescribers Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

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 process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

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