Makena Enrollment Form

Date: ______________

Patient Data

Patient Name: ______________ Birthdate: ______________
Sex: q Male q 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: ______________
Policy: ______________ Group#: ______________
Secondary Insurance: ______________
Policy: ______________ Group#: ______________

Diagnosis

q O09.212 Supervision of pregnancy with history of preterm labor, second trimester

q O09.213 Supervision of pregnancy with history of preterm labor, third trimester

q O09.219 Supervision of pregnancy with history of preterm labor, unspecified trimester

q Z87.51 Personal history of preterm labor

q Other: ______________

Clinical Information

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

Patient has had preterm birth q Yes, Specify gestation ______________ q No

Current gestational age ______________ weeks ______________ days Date recorded: ______/______/______

Is this medication to be used for a singleton pregnancy? q Yes q No, explain ______________

Makena must be started on or after 16 weeks gestation but before 21 weeks q Agree q Disagree, explain ______________

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

Start date of next injection ______/______/______

Gravity ______________ **Parity** ______________ **EDD** ______/______/______ **LMP** ______/______/______

Prescription

Medication	Directions	Frequency	Quantity	Refills
q Makena 250mg/ml *or generic*	Inject 1ml (250mg) intramuscularly	q every 7 days q ______________	q (#4) 1ml vials	
q Makena 275mg/1.1ml auto-injector	Inject 1.1ml (275mg) subcutaneously	q every 7 days q ______________	q #4 auto-injectors	

Supplies

q 1.5qt sharps

q Alcohol Swabs

q 18g 3ml 1.5” syringes (for withdrawing)

q 21g 3ml 1.5” needles (for injecting medication)

Is patient new to this therapy: q YES q NO | **Ship to:** q Patient q Office q 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.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**