



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

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
 Does patient have any of the following? History of fetal anomaly (birth defect) Seizure disorder History or plans of cervical cerclage None
 Start date of next injection ____/____/____
 Gravity _____ Parity _____ EDD ____/____/____ LMP ____/____/____

Prescription

Medication	Directions	Quantity	Refills
<input type="checkbox"/> Hydroxyprogesterone Caproate 250mg/ml FDA Approved Generic	Inject 1ml (250mg) intramuscularly once weekly	(#4) 1ml vials	
<input type="checkbox"/> Makena 275mg/1.1ml auto-injector	Inject 1.1ml (275mg) subcutaneously once weekly	#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

Prescriber 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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