



# Makena Enrollment Form

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<br>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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