

MAKENA (hydroxyprogesterone caproate) PRIOR AUTHORIZATION FORM

Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Makena** and **Quantity Limits/Daily Dose Limits**, accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	
<input type="checkbox"/> Renewal request	PA# _____	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Medication requested:		<input type="checkbox"/> Makena 250 mg/ml (1 ml) single-dose vial	<input type="checkbox"/> Makena 250 mg/ml (5 ml) multi-dose vial
Dose/directions: _____		Quantity: _____	Refills: _____
Diagnosis (<i>submit documentation</i>): <input type="checkbox"/> pregnancy with history of pre-term labor		<input type="checkbox"/> other: _____ (<i>Submit documentation supporting use of Makena for this diagnosis.</i>)	
DX codes (<i>required</i>): _____		Initial start date of Makena therapy: _____ / _____ / 20_____	
1. Makena is included in the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used?		<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy	
2. Is the Recipient currently pregnant with a single fetus?		<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No	
3. What is the current gestational age?		Weeks: _____ Days: _____	
4. Does the Recipient have a documented history of a prior spontaneous preterm singleton birth (defined as prior to 37 weeks' gestation)?		<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No	
5. Does the Recipient have any of the following contraindications to the use of Makena? <i>Check all that apply.</i>		<input type="checkbox"/> Yes <i>If yes, submit supporting documentation.</i> <input type="checkbox"/> No	
<input type="checkbox"/> current or history of thrombosis or thromboembolic disorders <input type="checkbox"/> history of or current known or suspected breast cancer or other hormone-sensitive cancer <input type="checkbox"/> undiagnosed abnormal vaginal bleeding unrelated to pregnancy <input type="checkbox"/> cholestatic jaundice of pregnancy <input type="checkbox"/> benign or malignant liver tumors or active liver disease <input type="checkbox"/> uncontrolled hypertension			
6. Does the Recipient have any of the following conditions? <i>Check all that apply.</i>		<input type="checkbox"/> Yes <i>If yes, submit supporting documentation.</i> <input type="checkbox"/> No	
<input type="checkbox"/> history of, or plans for, a cervical cerclage <input type="checkbox"/> known fetal anomaly <input type="checkbox"/> history of seizure disorder			

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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