Independence
Independence Administrators

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Makena® /17 Alpha-Hydroxyprogesterone Caproate

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: ☐ **Makena® single-dose vial** ☐ **Makena® multi-dose vial** ☐ **Makena® SC autoinjector**
☐ **Preservative-free compound (17 alpha-hydroxyprogesterone caproate)**

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

a. Is this a singleton pregnancy, confirmed by ultrasound? If yes, please fax the ultrasound results along with this form. ☐ Yes ☐ No

b. Is the patient currently in preterm labor with this singleton pregnancy? ☐ Yes ☐ No

c. Are there any risk factors for preterm birth in this patient (e.g., pregnancy-induced hypertension)? ☐ Yes ☐ No

d. Does the patient have a documented history of singleton spontaneous preterm birth (occurring between 20 weeks and 37 weeks gestation)? If yes, please fax this documentation along with this form. ☐ Yes ☐ No

e. Will the weekly injections be administered between 16 weeks 0 days and 36 weeks 6 days of gestation? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

_____

_____

_____

3) Prescription information

Quantity_____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-784-0672.