

**MAKENA**  
**(HYDROXYPROGESTERONE CAPROATE)**



**Keystone First**

**PERFORMRx**<sup>SM</sup>  
Next Generation Pharmacy Benefits

**PRIOR AUTHORIZATION FORM**

(form effective 1/5/21)

Fax to PerformRx<sup>SM</sup> at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:	
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:		Apt. #:	City/state/zip:
PRESCRIBER INFORMATION			
Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
Street address:		Suite #:	City/state/zip:
Phone:		Fax:	
PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION):			
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:			
Pharmacy Phone #:		Pharmacy Fax #:	
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.			
CLINICAL INFORMATION			
<b>Medication requested:</b>			
<input type="checkbox"/> hydroxyprogesterone caproate injection	<input type="checkbox"/> Makena 250 mg/ml (1 ml) single-dose vial (non-preferred)		
<input type="checkbox"/> Makena 275 mg/1.1 ml autoinjector*	<input type="checkbox"/> Makena 250 mg/ml (5 ml) multi-dose vial (non-preferred)		
<input type="checkbox"/> _____			
*preferred with clinical prior authorization required			
Dose/directions:		Quantity:	Refills:
Diagnosis (submit documentation): <input type="checkbox"/> pregnancy with history of pre-term labor <input type="checkbox"/> other: _____			
DX codes (required):		Start date of therapy: _____ / _____ / 20_____	
1. Is the patient currently pregnant with a single fetus?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit supporting documentation.
2. What is the current gestational age? Weeks: _____ Days: _____			
3. Does the patient have a documented history of a prior spontaneous pre-term singleton birth (defined as prior to 37 weeks' gestation)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit supporting documentation.
4. Does the patient have any of the following contraindications to the use of Makena? Check all that apply.			
<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			
5. For non-preferred products: Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agents?			
<input type="checkbox"/> hydroxyprogesterone caproate			
<input type="checkbox"/> Makena auto injector			

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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