



Universal 17-P/Makena Authorization Form

\*Fax the COMPLETED form OR call the plan with the requested information.\*

Phone: 1-800-454-3730 Fax: 1-800-359-5781

Date of Request for Authorization: \_\_\_\_\_

Patient/Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address (Street, Apt. #): \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ MCO ID #: \_\_\_\_\_

Pregnancy Information and History:

G\_\_ T\_\_ P\_\_ A\_\_ L\_\_ (Note: A=abortion (spontaneous and medically induced) EDC\_\_\_\_\_

Experiencing Preterm Labor:  Yes  No

Singleton Pregnancy  Multiple Pregnancy

Date When Patient Will be at 16 Weeks Gestation: \_\_\_\_\_

Major Fetal or Uterine Anomaly  Yes  No

Patient has a history of prior spontaneous singleton preterm birth between 16-36.6 weeks  Yes  No

Delivery was due to preterm labor or PPROM even if it resulted in a C-section  Yes  No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc.  Yes  No

Current or history of thrombosis or thromboembolic disorders  Yes  No

Known or suspected breast cancer, other hormone sensitive cancer or history of these conditions  Yes  No

Undiagnosed abnormal vaginal bleeding unrelated to pregnancy  Yes  No

Cholestatic jaundice of pregnancy  Yes  No

Liver tumors, benign or malignant, or active liver disease  Yes  No

Uncontrolled hypertension  Yes  No

Medication Allergies: (if none put N/A)

Other Pertinent Clinical Information: (if none put N/A)

Does the patient meet FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)?

Yes  No

Current Gestational Age: \_\_\_\_\_ week(s) \_\_\_\_\_ days

Date Recorded: \_\_\_\_\_

Is the patient currently receiving Makena?  Yes  No

Is the patient currently receiving compounded HPC (17P)?

Yes  No

### Complete and Sign Rx:

\_\_\_\_\_  
Prescriber's Name (Last, First)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Practice Name

\_\_\_\_\_  
Office Phone#

\_\_\_\_\_  
Office Fax #

\_\_\_\_\_  
NPI #

\_\_\_\_\_  
Office Tax ID #

\_\_\_\_\_  
Medicaid Provider #

\_\_\_\_\_  
Office Contact(s)

\_\_\_\_\_  
Direct Phone #

\_\_\_\_\_  
After-hours Phone #

\_\_\_\_\_  
Email

### ICD-10 Code:

O09.212 - Supervision of pregnancy with history of preterm labor, second trimester

O09.213 - Supervision of pregnancy with history of preterm labor, third trimester

O09.219 - Supervision of pregnancy with history of preterm labor, unspecified trimester

Yes  No

### Preferred Method of Communication:

Phone  Fax  Email

### RX:

Hydroxyprogesterone Caproate injection 250 mg/mL (J1725) (Makena)

Compounded 17-P

Dispense 4 x 1 mL single-dose, preservative-free vials (64011-247-02) X \_\_\_\_\_ refills

Sig: Inject 1 mL IM each week

18-g needles & 3 mL syringe \_\_\_\_\_ #

21-g 1 1/2 needle \_\_\_\_\_ #

### Please Ship To:

Prescriber  Patient

### Preferred Injection Setting:

Healthcare Provider Office

Home Health Care agency, if approved by insurance

Write in agency name:

\_\_\_\_\_

Desired Start Date: \_\_\_\_\_

Desired End Date: \_\_\_\_\_

*I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.*

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dispense As Written/Do Not Substitute