Independence

Today's date _____

Date medication needed _____

Prior Authorization Form

Hydroxyprogesterone Caproate (Makena™ OR Preservative-free Compound)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

SELECT ONE: ☐ **Makena™** ☐ **Preservative-free Compound** (17 alpha-hydroxyprogesterone caproate [17P])

Patient information

Patient Name_____

Address _____

City, State, ZIP_____

Patient Telephone # _____

Patient ID # _____

Date of Birth _____ Height _____ Weight _____

Physician information

Prescribing Physician _____

Office Address _____

City, State, ZIP _____

Office Contact _____

Office Telephone # _____

Fax # _____ NPI _____

Upon approval, delivery is available by completing the section below.

☐ **N/A – No delivery requested, authorization only — physician will use office supply.**

☐ **Delivery requested (indicate where medication should be delivered: ❍ Physician's office ❍ Patient's home)**

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

1. **Physician specialty (required; specify all specialties)** _____

2. **Diagnosis for drug requested (must include ICD-9):**

   ☐ V23.41 Pregnancy with history of pre-term labor ☐ Other (specify ICD-9) _____

3. **Patient medical information:**

   a. Is the patient currently at risk of pre-term birth with singleton pregnancy? ☐ Yes ☐ No
   b. Are there any risk factors for pre-term birth (such as pregnancy-induced hypertension)? ☐ Yes ☐ No
   c. Is there a history of singleton spontaneous pre-term birth (occurring < 37 weeks gestation)? ☐ Yes ☐ No
   d. Has an ultrasound confirmed gestational age between 16 weeks and 37 weeks? ☐ Yes ☐ No

4. **Patient history (please list any previous or current therapies related to the diagnosis):**

Drug name	Dates	Duration

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

_____

_____

5. **Prescription information:**

Quantity _____ Refill x _____month(s)

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

Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.

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