# Makena® Referral/Prescription Form

To ensure enrollment, please fax to the Makena Care Connection® (1-800-847-3413)
Telephone 1-800-847-3418 • www.makena.com

Makena®
hydroxyprogesterone
caproate injection

## STEP 1 — Complete Patient and Insurance Information (Required; please include copies of front and back of insurance cards)

Clear Field

First Name | Last Name | MI

Address

City | State | ZIP

Home Phone | Work Phone

Cell Phone | Best Time to Contact | Email

Date of Birth | Primary Language if Not English:

Known Allergies:

☐ Patient does not have insurance  Does patient have prescription drug card? ☐ Yes ☐ No

Prescription Drug Insurer/Pharmacy Benefit Manager | BIN #

ID # | Group # | Phone

Primary Medical Insurance | Cardholder Name

Date of Birth | Policy ID Number

Phone | Relationship to Cardholder

Secondary Medical Insurance | Cardholder Name

Date of Birth | Policy ID Number

Phone | Relationship to Cardholder

## STEP 2 — Read and Sign Patient Authorization (Optional, however signature is required for financial assistance)

Clear Field

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to Ther-Rx Corporation — the Makena Care Connection — and its representatives, agents, and contractors (collectively "Ther-Rx") for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to contact me with branded support materials related to my treatment. I understand that my Personal Health Information disclosed under this authorization may be redisclosed by Ther-Rx and is no longer protected by federal privacy laws. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Ther-Rx Corporation, 6900 Dallas Parkway, Suite 200, Plano, TX 75024, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below.

**X** Patient or Legal Guardian Signature: _____ Relationship to Patient: _____ Date: _____

## STEP 3 — Patient Eligibility (Required)

Clear Field

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: _____ Weeks _____ Days _____ Date Recorded (MM/DD/YY)

Currently on 17P ☐ Yes ☐ No

Please note that to be eligible for Makena Care Connection services (e.g., patient assistance programs and patient education materials), the patient must meet the FDA-approved indication.

If a patient does not meet the FDA-approved indication, the prescription will be sent directly to a Specialty Pharmacy for appropriate processing. Insurance coverage of Makena will be made at the determination of the individual's health plan.

## STEP 4 — Complete and Sign Makena Rx (Required)

Clear Field

Prescriber's Name (Last, First) | Specialty

Address

City | State | ZIP

Practice Name | Office Phone | Office Fax

NPI #

Medicaid Provider #

Office Contact(s) | Direct Phone

After-hours Phone | Email

Rx: Makena (hydroxyprogesterone caproate injection)
250 mg/mL, 5 mL multidose vial

☐ Dispense 1 vial, followed by _____ refills for a complete course of therapy

Sig: Inject 1 mL IM each week

**Preferred Injection Setting:**
☐ Healthcare provider office
☐ Home via home health provider (if approved by patient's insurer)

**Please ship Makena to:**
☐ Prescriber
☐ Patient

**Ancillary Supplies:**
☐ 18-g needle & 3 mL syringe _____ #
☐ 21-g, 1 1/2" needle _____ #

**Anticipated Start Date:** _____ **(MM/DD/YY)**

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

**X** Prescriber's Signature: _____ Date: _____

## STEP 5 — Read and Sign Prescriber Authorization (Required)

Clear Field

I authorize CDF Services, LP (CDF Services), to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with the Makena Care Connection to the insurer of such patients and/or my patient, and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103) from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. CDF Services may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, CDF Services is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

**X** Prescriber's Signature: _____ Date: _____

**Fax completed form and insurance cards (front and back) to: 1-800-847-3413**

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