

Makena® (hydroxyprogesterone caproate injection)

Submit fax request to: 855-455-3303

Purpose: For a prescribing physician to request prior authorization for Makena® (hydroxyprogesterone caproate injection).

Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	Specialty:
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name: Makena®	Strength:	
Dosage:	Duration:	
CLINICAL INFORMATION		
<i>Check the applicable boxes to indicate each item as true for the recipient:</i>		
<input type="checkbox"/> The member is pregnant with a singleton pregnancy.		
<input type="checkbox"/> Makena® is being ordered or recommended by a physician specializing in Obstetrics/Gynecology, Perinatology or Maternal/Fetal medicine.		
<input type="checkbox"/> The recipient has a history of singleton spontaneous preterm birth (prior to 37 weeks gestation).		
<input type="checkbox"/> The recipient's pregnancy will be between 16 weeks, 0 days and 20 weeks, 6 days of gestation when therapy begins.		
<input type="checkbox"/> There is no known major fetal anomaly or fetal demise.		
<input type="checkbox"/> The recipient does not have other risk factors for preterm birth.		
<input type="checkbox"/> The recipient has not received heparin therapy during the current pregnancy.		
<input type="checkbox"/> The recipient does not have a history of thromboembolic disease.		
<input type="checkbox"/> The recipient does not have any maternal/obstetrical complications (e.g., current or planned cerclage, hypertension requiring medication or seizure disorder).		
Quantity limit: 1 vial per 30 days (5 doses)		
Approval duration: Until the recipient's pregnancy is 36 weeks, 6 days of gestation or delivery, whichever occurs first.		
Additional clinical information (if applicable):		
PROVIDER CERTIFICATION – Prescriber's signature and date required.		
I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.		
Prescriber's Signature: _____		Date: _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.