Prior Authorization Request
Nevada Medicaid – OptumRx

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: ☐ Male ☐ 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

Check the applicable boxes to indicate each item as true for the recipient:

- ☐ The member is pregnant with a singleton pregnancy.
- ☐ Makena® is being ordered or recommended by a physician specializing in Obstetrics/Gynecology, Perinatology or Maternal/Fetal medicine.
- ☐ The recipient has a history of singleton spontaneous preterm birth (prior to 37 weeks gestation).
- ☐ The recipient's pregnancy will be between 16 weeks, 0 days and 20 weeks, 6 days of gestation when therapy begins.
- ☐ There is no known major fetal anomaly or fetal demise.
- ☐ The recipient does not have other risk factors for preterm birth.
- ☐ The recipient has not received heparin therapy during the current pregnancy.
- ☐ The recipient does not have a history of thromboembolic disease.
- ☐ 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:** _____