



Optum Specialty Phone: 855-427-4682
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Makena® (17P) Enrollment Form
(hydroxyprogesterone caproate injection)

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Current Pregnancy:
Current Gestational Age: _____ weeks _____ days
Date recorded _____
Is this a singleton pregnancy? Yes No
Is the patient experiencing preterm labor? Yes No
Does the patient have cerclage? Yes No
Is there a known fetal anomaly? Yes No

Please select all that apply:

Known, suspected, or history of breast cancer or other hormone-sensitive cancer?
 Current or history of thrombosis or thromboembolic disorders?
 Undiagnosed abnormal vaginal bleeding unrelated to pregnancy?
 Cholestatic jaundice of pregnancy?
 Liver tumors (benign or malignant) or active liver disease?
 Uncontrolled hypertension?
 None of the above

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

O09.211 Supervision of pregnancy with history of pre-term labor, first trimester
 Other Diagnosis: ICD-10 Code _____ Description _____
Is the patient currently on compounded HPC (17P)? Yes No

OB History:
Gravida: 0 1 2 3 Other _____
Para: 0 1 2 3 Other _____
Gestational age of prior preterm birth _____ weeks
Has the patient had a previous spontaneous singleton preterm birth (earlier than 37 weeks gestation)? Yes No
Has the patient had any previous preterm birth? Yes No
If YES, please check indication(s) that apply:
 Multiple gestation Fetal complications Incompetent cervix
 Maternal complications—premature rupture of membranes
Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Dose /Strength	Directions	Quantity	Refills
<input type="checkbox"/> Makena® (17P) (hydroxyprogesterone caproate injection)	250 mg/mL 1 mL Vial	Inject 1 mL IM each week		
<input type="checkbox"/> Makena® auto-injector (hydroxyprogesterone caproate)	275 mg/1.1 mL auto-injector	Inject 1.1 mL (275 mg) SC once weekly		
<input type="checkbox"/> 18-g needle & 3mL syringe				
<input type="checkbox"/> 21-g, 1 1/2" needle				

Supplies Needed (if medication is to be administered in patient's home): If checked, please specify the size and type is applicable
 Syringes/Needles Swabs Sharps Container Other: _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____
 Product Substitution permitted Dispense as Written
Prescriber's Signature _____ Date _____ Supervising Physician Signature _____ Date _____
Electronic or digital signatures not accepted.

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