

Ticket #: _____ Request Date: _____ Request Time: _____

Makena® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Reduce risk of preterm birth	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Has the patient had a previous singleton (single offspring) spontaneous preterm birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient currently have a singleton pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will therapy with Makena be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will therapy with Makena be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Makena prescribed by or in consultation with a gynecologist or obstetrician? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.
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