Makena Enrollment Form

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ____ kg _____
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Diagnosis

☐ O09.212 Supervision of pregnancy with history of preterm labor, second trimester

☐ O09.213 Supervision of pregnancy with history of preterm labor, third trimester

☐ O09.219 Supervision of pregnancy with history of preterm labor, unspecified trimester

☐ Z87.51 Personal history of preterm labor

☐ Other: _____

Clinical Information

Please attach clinical office notes and ultrasound report, if available, to expedite the prior authorization

Patient has had preterm birth ☐ Yes, Specify gestation _____ ☐ No

Current gestational age _____ weeks _____ days Date recorded: _____/_____/_____

Is this medication to be used for a singleton pregnancy? ☐ Yes ☐ No, explain _____

Makena must be started on or after 16 weeks gestation but before 21 weeks ☐ Agree ☐ Disagree, explain _____

Makena must be stopped at 36 weeks, 6 days gestation or delivery, whichever comes first ☐ Agree ☐ Disagree

Does patient have any of the following? ☐ History of fetal anomaly (birth defect) ☐ Seizure disorder ☐ History or plans of cervical cerclage ☐ None

Start date of next injection _____/_____/_____

Gravity _____ **Parity** _____ **EDD** _____/_____/_____ **LMP** _____/_____/_____

Prescription

Medication	Directions	Quantity	Refills
☐ Hydroxyprogesterone Caproate 250mg/ml *FDA Approved Generic*	Inject 1ml (250mg) intramuscularly once weekly	(#4) 1ml vials	
☐ Makena 275mg/1.1ml auto-injector	Inject 1.1ml (275mg) subcutaneously once weekly	#4 auto-injectors	

Supplies

☐ 1.5qt sharps ☐ Alcohol Swabs ☐ 18g 3ml 1.5" syringes (for withdrawing) ☐ 21g 3ml 1.5" needles (for injecting medication)

Is patient new to this therapy: ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.