PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Makena® (hydroxyprogesterone caproate)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Makena 250 mg/mL injection
- ☐ Makena 275 mg/1.1 mL auto-injector

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Current gestational age: _____ weeks, _____ days

Place of administration:
- ☐ Physician's office
- ☐ Outpatient infusion
  - Facility: _____ NPI: _____ Fax: _____
- ☐ Home infusion
  - Facility: _____ NPI: _____ Fax: _____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  - Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used to reduce the risk of preterm birth
2. Must be a singleton pregnancy
3. Woman must have a history of a prior spontaneous preterm birth of singleton pregnancy
4. The first weekly injection of Makena must be started on or after 16 weeks gestation, but before 27 weeks gestation
5. Makena must be stopped at 36 weeks, 6 days gestation or delivery, whichever comes first
6. Must first try generic hydroxyprogesterone caproate

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2016
Last reviewed 05/2018

Additional information

Priority Health supports the prescriber's discretion to use either Makena or compounded preservative-free 17-P based on the facts and circumstances of the individual patient. The compounded formulation will continue to be a covered alternative and does not require prior approval.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Reduce risk of preterm birth
☐ Other – the patient's condition is: _____

B. Will Makena be used for a singleton pregnancy?

☐ Yes ☐ No – explain why Makena is required: _____

C. Does the patient have a history of a spontaneous preterm birth of singleton pregnancy?

☐ Yes ☐ No – explain why Makena is required: _____

D. At what gestational age will (or was) the first Makena injection be given? _____ weeks, _____ days

E. Has the member tried generic hydroxyprogesterone caproate?

☐ Yes ☐ No – explain why Makena is required: _____

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