OPTUM®

Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

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
☐ **Makena® (17P)** (hydroxyprogesterone caproate injection)	250 mg/mL 1 mL Vial	Inject 1 mL IM each week		
☐ **Makena® auto-Injector** (hydroxyprogesterone caproate)	275 mg/1.1 mL auto-injector	Inject 1.1 mL (275 mg) SC once weekly		
☐ **18-g needle & 3mL syringe**				
☐ **21-g, 1½" 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.