MC-Rx
Powered by ProCare Rx

Makena®

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Reduce risk of preterm birth

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient had a previous singleton (single offspring) spontaneous preterm birth? ❑ **Yes** ❑ **No**

Does the patient currently have a singleton pregnancy? ❑ **Yes** ❑ **No**

Will therapy with Makena be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation? ❑ **Yes** ❑ **No**

Will therapy with Makena be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first? ❑ **Yes** ❑ **No**

Is Makena prescribed by or in consultation with a gynecologist or obstetrician? ❑ **Yes** ❑ **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:

MC-Rx 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.