PRIOR AUTHORIZATION REQUEST

Makena

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Reduce risk of preterm birth
   - ☐ Other - Please specify _____
2. ☐ Yes ☐ No Is the patient pregnant with a singleton pregnancy? Note: singleton means not twins or other multiples
3. ☐ Yes ☐ No Does the patient have a history of a singleton spontaneous preterm birth (SPTB) prior to 37 weeks gestation?
4. ☐ Yes ☐ No Will treatment begin in patients who are at least 16 weeks, 0 days of gestation, according to the prescribing physician or other prescriber?
5. ☐ Yes ☐ No Has the patient already started therapy with the requested medication?
6. How many injections has the patient received?
   - ☐ 1 to 4 injections
   - ☐ 5 to 8 injections
   - ☐ 9 to 12 injections
   - ☐ 13 to 16 injections
   - ☐ 17 to 20 injections
   - ☐ 21 injections
7. ☐ Yes ☐ No Is the current gestational age less than 37 weeks (for example, there was an inaccuracy in dating the pregnancy)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851