

Makena® Prior Authorization Request Form (Page 1 of 2)

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information <small>(required)</small>
Select the diagnosis below: <input type="checkbox"/> Reduce risk of preterm birth <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information: Has the patient had a previous singleton (single offspring) spontaneous preterm birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient currently have a singleton pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Will therapy with Makena be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation? <input type="checkbox"/> Yes <input type="checkbox"/> No Will therapy with Makena be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Makena prescribed by or in consultation with a gynecologist or obstetrician? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

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1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ Date: _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
Approved, through					
Denied (documentation attached, if necessary)					
Tracking:					
1 st Attempt		2 nd Attempt		Letter Mailed:	