Fill at Delmarva Pharmacy

Johns Hopkins HealthCare

Makena Prior Authorization Request Form

For Priority Partners, EHP and USFHP

Internal Use Only:

PA#:

Date:

1. Complete form below.
2. Fax completed form and member office visit notes to JHHC Pharmacy Review at fax: 410-424-4607 or 410-424-4751
3. Upon decision, provider will be notified of outcome via fax. If approved, authorization and prescription information will be sent directly to network dispensing specialty pharmacy.

*For authorization questions, please call JHHC Pharmacy Review at: 888-819-1043, option 4

**For questions concerning delivery, please contact specialty pharmacy in member specific approval letter

Member Information		
Name:		Health Plan: ☐ EHP ☐ PPMCO ☐ USFHP
DOB:	ID#:	PPMCO MA#:
Provider Information		
Name:		Phone:
Office Contact:		Fax:
Provider NPI:		
Office Address:		
Prescription Information		
RX: Makena (hydroxyprogesterone caproate injection) 250mg/ml Sig: Inject 1ml each week		
IDC-10 Code:		
Dispense: ☐ 1ml single-dose, PF vials, QTY _____ **☐ 18-g needle and 3ml syringe, QTY _____ ☐ 21-g 1 ½" needle, QTY _____** **_____Refills Allowed**		
Member Eligibility		
Will the patient be treated with a cerclage in addition to Makena? ☐ Yes ☐ No *Requests for patients receiving a cerclage will be denied.*		
Current gestational age **as confirmed by ultrasound**: _____ weeks _____ days Date recorded: _____		
Singleton pregnancy? ☐ Yes ☐ No		
History of spontaneous preterm birth less than 37 weeks of gestation? ☐ Yes ☐ No		
Is the patient currently receiving Makena? ☐ Yes ☐ No		
Is the patient currently receiving compounded HPC (17P)? ☐ Yes ☐ No		
Attestation		
☐ Prescriber must submit documentation of gestational age based on ultrasound. ☐ I certify that the clinical information provided on this form is complete and accurate: Provider Signature: _____ Date: _____		
For Internal Use Only		
Decision:	Duration of Approval: _____	
	Authorized By/Date:	