Delmarva Pharmacy

Makena Prior Authorization Form

Telephone: 410-677-0561 | www.delmarvapharmacy.com | Fax: 410-630-8368

DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

Makena® hydroxyprogesterone caproate injection

Patient Information	Prescriber Information
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone:	Office Contact:
Patient ID:	Phone:
DOB (m/d/y):	Fax:
Hgt (inches):	NPI#:
Wgt (lbs.):	DEA#:

Physician's Specialty: _____

Drug Requested w/ Instructions

Drug	Strength	Directions	Quantity per 30 days
Makena	250mg/mL	_____	_____

Diagnosis

V23.41 (pregnancy w/ history of pre-term labor) ☐

Other:_____(Specify ICD-9)

Other Medication Information

Patient current gestation age:	Weeks	Days
Date Makena therapy to be initiated:		
Patient currently pregnant with:	☐ Singleton	☐ Multiples
Medication to be supplies from:	☐ Delmarva Pharmacy	☐ Other (Theracom, etc.)
Medication to be administered via:	☐ Physician's Office	☐ Home Healthcare Agency

_____ _____

Prescriber or Authorized Signature **Date**

Ins. Company Name:
Ins. Company Phone:
Ins. Company Fax:
Ins. Company BIN#:
Approved: ☐ If approved, duration of treatment: ☐ 6 months ☐ 1 year
If denied, reason for denial:
Person Approving Authorization: _____

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Phone: 410-677-0561 Fax: 410-677-0562 Attn: Shawn Eisemann, PharmD

Submit