Amerigroup RealSolutions in healthcare

Provider update

Important information regarding 17-alpha-hydroxyprogesterone caproate (17P)/Makena

Prescription and administration

Should you wish to prescribe this medication for your patients after reviewing their obstetrical history and drug indications, please consider the following regarding delivery and administration:

- For office administration and/or home health administration of either injectable compounded 17P (J3490) or Makena® (J1725), prior authorization (PA) is required. Please contact Provider Services at 1-800-454-3730 to initiate a precertification request or fax the request using the *Universal 17-P/Makena Authorization Form* to 1-888-302-1028.
- For your convenience the form is accessible at https://providers.amerigroup.com/GA under *Forms*.

About 17P/Makena

For women who have had a prior preterm delivery, studies have shown weekly administration of 17P/Makena (beginning in the second trimester) reduces the chance of preterm delivery in subsequent pregnancies by as much as 33 percent. The rates of several complications of prematurity (e.g., necrotizing enterocolitis, intraventricular hemorrhage and the need for supplemental oxygen) were also decreased among the infants of women treated with 17P/Makena. As with any drug, certain risks may outweigh these benefits.

What if I need assistance?

If you have questions about this communication, wish to discontinue receiving these provider alerts or have received this fax in error, please contact Provider Services at 1-800-454-3730. You can also contact an Amerigroup Community Care OB/GYN case manager at 1-800-600-4441.

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https://providers.amerigroup.com

Universal 17-P/Makena Authorization Form

Fax the completed form or call Amerigroup Community Care with the requested information.
Phone: 1-800-454-3730 Fax: 1-888-302-1028

Date of request for authorization			
Patient/member name			
DOB		Phone	
Medicaid ID number		Amerigroup ID number	
Address			
City, State ZIP code			

Pregnancy information and history:

☐G ☐T ☐P ☐A ☐L Note: A — abortion (spontaneous or medically induced) ☐EDC			
Experiencing preterm labor:	☐Yes	☐No	
Pregnancy type:	☐Singleton pregnancy	☐Multiple pregnancy	
Patient currently has or plans to have cervical cerclage with this pregnancy		☐Yes	☐No
Date when patient will be at 16 weeks gestation:			
Major fetal or uterine anomaly		☐Yes	☐No
Patient has a history of prior spontaneous singleton preterm birth at 16-36.6 weeks		☐Yes	☐No
Delivery was due to preterm labor or PPROM even if it resulted in a C-section		☐Yes	☐No
Delivery was due to medical indication such as pre-eclampsia, abruption, etc.		☐Yes	☐No
Current or history of thrombosis or thromboembolic disorders		☐Yes	☐No
Known or suspected breast cancer, other hormone-sensitive cancer or history of these conditions		☐Yes	☐No
Undiagnosed, abnormal vaginal bleeding unrelated to pregnancy		☐Yes	☐No
Cholestatic jaundice of pregnancy		☐Yes	☐No
Liver tumors, benign or malignant, or active liver disease		☐Yes	☐No
Uncontrolled hypertension		☐Yes	☐No
Medication allergies (if none, enter N/A):			
Other pertinent clinical information (if none, enter N/A):			
Does the patient meet FDA-approved indication? (Current pregnancy is singleton, and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation.)		☐Yes	☐No
Current gestational age in week(s) and days		__ Week(s)	___ Days
Date gestational age recorded			
Is the patient currently receiving Makena?		☐Yes	☐No
Is the patient currently receiving compounded HPC (17-P)?		☐Yes	☐No

Complete and sign Rx:

Prescriber's name (Last, First)		
Address		
City, State ZIP code		
Practice name	Phone	Fax
NPI	Office tax ID	
Medicaid provider ID		
Office contact(s)	Direct phone	
After-hours phone	Email	

ICD-10 code:
☐ O09.212 — Supervision of pregnancy with history of preterm labor, second trimester
☐ O09.213 — Supervision of pregnancy with history of preterm labor, third trimester
☐ O09.219 — Supervision of pregnancy with history of preterm labor, unspecified trimester
☐ Yes ☐ No

Preferred method of communication: ☐ Phone ☐ Fax ☐ Email

Rx:
☐ Hydroxyprogesterone caproate injection 250 mg/mL (J1725) (Makena)
☐ Compounded 17-P
☐ Dispense 4 x 1 mL single-dose, preservative-free vials (64011-247-02) X _____ refills
☐ Sig: Inject 1 mL IM each week
☐ 18-g needles and 3 mL syringe _____ # 21-g 1½
☐ Needle _____ #

Please ship to: ☐ Prescriber ☐ Patient

Preferred injection setting:
☐ Health care provider office
☐ Home health care agency (HHCA) if approved by insurance — prescriber must contact HHCA of choice
Write in HHCA name: _____
Desired start date: _____ Desired end date: _____

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

_____ _____
Prescriber's signature Date

☐ Dispense as written/do not substitute.