Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Universal 17P/Makena Prior Authorization Form with Prescription

Effective August 1, 2018, all 17P and Makena® prior authorization (PA) forms must be sent to Amerigroup Community Care by fax at 1-844-490-4736. PA reviews may also be submitted by phone at 1-800-454-3730 or through the electronic PA (ePA) system at www.covermymeds.com. Once you receive PA approval, fax a Makena prescription or the *Universal 17P/Makena PA Form* to Accredo Specialty Pharmacy at 1-888-302-1028. For 17P prescriptions, fax the prescription or the *Universal 17P/Makena PA Form* to an in-network pharmacy with compounding capability. For questions about a PA request, call Amerigroup Provider Services at 1-800-454-3730. For questions about a Makena prescription, call Accredo Specialty Pharmacy at 1-800-870-6419.

Patient information			
Name:	DOB:		
Phone:	Date of request for authorization:		
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			
Current gestational age in week(s) and days:			
Date gestational age recorded:			
Date when patient will be at 16 weeks' gestation:			
Experiencing preterm labor: ☐ Yes ☐ No	Pregnancy type: ☐ Singleton ☐ Multiple		
Patient currently has or plans to have cervical cerclage with this pregnancy		☐ Yes	☐ No
Major fetal or uterine anomaly		☐ Yes	☐ No
History of prior spontaneous singleton preterm birth at 16-36.6 weeks		☐ Yes	☐ No
Prior delivery was due to preterm labor or PPROM, even if it resulted in a C-section		☐ Yes	☐ No
Prior delivery was due to medical indication (e.g., pre-eclampsia, abruption)		☐ Yes	☐ No
Currently has or history of thrombosis or thromboembolic disorders		☐ Yes	☐ No
Currently has or history of known or suspected breast cancer or other hormone-sensitive cancer		☐ 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):			

Pregnancy information and history		
Other pertinent clinical information (if none, enter N/A):		
Does the patient meet FDA-approved indication? (i.e., Current pregnancy is singleton, and patient has a history of singleton spontaneous preterm birth less than 37 weeks' gestation.)	☐ Yes	☐ No
Is the patient currently receiving Makena?	☐ Yes	☐ No
Is the patient currently receiving compounded HPC (17P)?	☐ Yes	☐ No

Complete and sign to prescribe

Prescriber name: _____ Practice name: _____

Phone: _____ Fax: _____ Email: _____

NPI: _____ Medicaid provider ID: _____

Address: _____ City, state, ZIP: _____

Office tax ID: _____ Contact person: _____

Phone: _____ After-hours phone: _____

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

Preferred method of communication: ☐ Phone ☐ Fax ☐ Email

Rx: (Select one product.) Must be administered by a health care professional.

☐ **Makena auto-injector** (PF) 275 mg/1.1mL
  ☐ Sig: Inject 275 mg (1.1 mL) SQ each week
☐ **Makena (Hydroxyprogesterone caproate) injection** 250 mg/mL (J1726)
☐ **Compounded 17P**
  ☐ Dispense 4 x 1 mL single dose, preservative-free vials (64011-247-02) X _____ refills
  ☐ Sig: Inject 1 mL IM each week
  ☐ 18 gauge needles and 3 mL syringe _____ #
  ☐ 21 gauge 1½-inch needle _____ #

Please ship to: ☐ Prescriber ☐ Patient

Preferred injection setting: ☐ Provider office
☐ Home health care agency (Provider must submit a pre-authorization request through the Availity Portal at: https://providers.amerigroup.com/GA.)

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

_____ _____

Prescriber signature Date

☐ Dispense as written/do not substitute.