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Makena Prior Authorization Form

Fax to: 1-844-512-7025
Phone: 1-800-454-3730 Date: _____

Please note: Makena is covered under the medical benefit only. This request should be fulfilled via Caremark Medical Specialty in Monroeville, Pennsylvania (NPI: 1043382302), Entrust Rx, **or** buy and bill. Once approval is received, fax the approval letter **and** order form to Caremark Medical Specialty or Entrust Rx.
Caremark Medical Specialty — Fax: 1-866-336-8479 Phone: 1-877-254-0015
Entrust Rx — Fax: 1-855-273-3925 Phone: 1-855-273-3924

Section I — member and provider information

1. Member name (last, first, middle initial):

2. Member identification number:	3. Member date of birth:
4. Prescriber name:	5. Prescriber NPI:
6. Prescriber address:	7. Prescriber phone:

Section II — billing facility information

Facility/pharmacy name:	Contact:
NPI #:	DEA #:
Phone:	Fax:

Section III — clinical information

8. Is this a single pregnancy? Yes ☐ No ☐

9. Does mother have any of the following:
- Prior cervical cerclage
- A uterine anomaly
- Positive tests for Cervicovaginal Fetal Fibronectin
- Experience of preterm labor within the current pregnancy

Yes ☐ No ☐

10. Does the mother have prior history of a preterm delivery before 37 weeks' gestation due to either of the following:
- Spontaneous preterm labor
- Premature rupture of membranes

Yes ☐ No ☐

11. List the gestational age at birth and associated dates of pregnancy for the member's prior preterm delivery.
_____weeks _____ days

12. Will Makena be administered weekly between weeks 16 and 36 of gestation? Yes ___ No___

13. Provide the current gestational age:_____weeks_____days Date confirmed: _____

14. Case-specific diagnosis/ICD-10: _____

Section IV — authorized signature	
15. **Prescriber signature:**	16. Date signed:
Section V — additional information	
17. Indicate any additional information in the space provided below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.	