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# Makena/Hydroxyprogesterone Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.**

| 1. Patient information | 2. Physician information |
|---|---|
| Patient name: ______________________ | Prescribing physician: ______________________ |
| Patient ID #: ______________________ | Physician address: ______________________ |
| Patient DOB: ______________________ | Physician phone #: ______________________ |
| Date of Rx: ______________________ | Physician fax #: ______________________ |
| Patient phone #: ______________________ | Physician specialty: ______________________ |
| Patient email address: ______________________ | Physician DEA: ______________________ |
| | Physician NPI #: ______________________ |
| | Physician email address: ______________________ |

| 3. Medication | 4. Strength | 5. Directions | 6. Quantity per 30 days |
|---|---|---|---|
| Makena | | | Specify: |
| 7. Diagnosis: | | | |

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes □ No Does the client have a diagnosis of singleton pregnancy
□ Yes □ No Does the client have a history of spontaneous singleton preterm birth?
□ Yes □ No Is the client between 16w0d and 20w6d gestation?
□ Yes □ No Does the client have a history of any of the following: thromboembolic disorders, known or suspected breast cancer, abnormal vaginal bleeding unrelated to pregnancy, cholestatic jaundice of pregnancy, liver tumors or active liver disease, and/or uncontrolled hypertension?
□ Yes □ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days?
□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class?
□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions?

NOTE: Makena/Hydroxyprogesterone caproate requests may be submitted for approval just prior to 16 weeks, zero days gestation

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **http://www.txvendordrug.com/formulary/formulary-search.asp**.

**9. Physician signature**

| | |
|---|---|
| ___________________________________ Prescriber or authorized signature | ___________________________ Date |

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.* Note: Payment is subject to member eligibility. Authorization does not guarantee payment.