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Makena 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

Patient name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____
Patient phone #: _____
Patient email address: _____

2. Physician information

Prescribing physician: _____
Physician address: _____
Physician phone #: _____
Physician fax #: _____
Physician specialty: _____
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?

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

For the *Preferred Drug List*, please refer to the Texas Vendor Drug Program website at https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Patient name: _____ Patient ID #: _____

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.