

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

2. Physician information

| | |
|---|--|
| Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____ | 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.)

| | | |
|---|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the client have a diagnosis of singleton pregnancy? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the client have a history of spontaneous singleton preterm birth? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is the client between 16w0d and 20w6d gestation? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> 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? |
| <p>NOTE: Makena requests may be submitted for approval just prior to 16 weeks, zero days gestation</p> <p>For the <i>Preferred Drug List</i>, please refer to the Texas Vendor Drug Program website at https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs.</p> | | |

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.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.