OPTIMA HEALTH COMMUNITY CARE (MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed**.

Drug Requested: Makena™ (17-hydroxyprogesterone caproate -17-OHPC) **(J1726) (Medical)**

- ❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

- ❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

DRUG INFORMATON: Complete **all** information below or authorization will be delayed.

Drug Form/Strength/Quantity/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSING:

Administer IM at a dose of 250mg (1mL) once weekly. Begin treatment between 16 weeks 0 days and 20weeks 6 days of gestation. Continue administration once weekly until 37 (through 36 weeks 6 days) of gestation or delivery, whichever occurs first. 5mL multidose vial (250mg/mL) contains 1250mg hydroxyprogesterone caproate 1 vial/month

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **MUST** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- ❑ Member has a history of previous spontaneous birth at less than 37 weeks gestation and current pregnancy is a singleton pregnancy
- ❑ Calculate EDC/EDD: _____
- ❑ Current gestational age: _____ weeks: _____ days: _____

(Continued on next page; signature page MUST be attached to form)

(Signature page MUST be included with form)

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 3/31/2009
REVISED/UPDATED: ~~6/2/2011; 8/18/2011; 4/2/2012; 4/19/2012; 10/1/2012; 4/9/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/17/2015; 7/8/2015; 12/30/2015; 1/29/2016; 8/18/2016; 9/22/2016; 12/11/2016; 7/24/2017; 2/9/2018; 3/17/2019; 5/8/2019;~~ **(Reformatted)** **7/17/2019**;