OPTIMA HEALTH COMMUNITY CARE

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 1-844-348-3720. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.***

Drug Requested: **Makena**™ (17-hydroxyprogesterone caproate -17-OHPC) **(J1725)** ***(Medical)***

DRUG INFORMATON: Complete information below. If incomplete, authorization process 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: All criteria below MUST be met to qualify. If incomplete, authorization process will be delayed.

- ❑ Patient 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: ________

Medication being provided by (check applicable box below):

❑ **Physician's office**

OR

❑ **Specialty Pharmacy*****:***   ❑ **Proprium Rx**

*****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.

Patient Name: ____

Member Optima #: ____________________________________ Date of Birth: __________________

Prescriber Name: ____

Prescriber Signature: ______________________________________ Date: ____________________

Office Contact Name: ____

Phone Number: __________________________________ Fax Number: ____________________

DEA OR NPI #: ____

REVISED/UPDATED: 8/1/2017