

# OPTIMA HEALTH PLAN

## 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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

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

**DRUG INFORMATION:** 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 20 weeks 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:

Briova SpecialtyRx

**\*\*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 #: \_\_\_\_\_

\*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; 11/29/2016; 12/13/2016; 9/15/2017; 10/4/2017