# 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 1-844-723-2094. 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) **(J1726)** ***(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:** ❑ **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.****

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; 12/11/2016; 7/24/2017;~~ **2/9/2018**;