



Optum Specialty Phone: 855-427-4682  
Optum Specialty Fax: 877-342-4596

**Makena® (17P) Enrollment Form**  
(hydroxyprogesterone caproate injection)

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

**PATIENT INFORMATION**

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
Language Preference:  English  Spanish  Other \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Group/Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION** (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

**MEDICAL INFORMATION** (Section must be completed to process prescription) (Attach separate sheet if needed)

**Current Pregnancy:**

Current Gestational Age: \_\_\_\_\_ weeks \_\_\_\_\_ days  
Date recorded \_\_\_\_\_  
Is this a singleton pregnancy?  Yes  No  
Is the patient experiencing preterm labor?  Yes  No  
Does the patient have cerclage?  Yes  No  
Is there a known fetal anomaly?  Yes  No

**Please select all that apply:**

- Known, suspected, or history of breast cancer or other hormone-sensitive cancer?
- Current or history of thrombosis or thromboembolic disorders?
- Undiagnosed abnormal vaginal bleeding unrelated to pregnancy?
- Cholestatic jaundice of pregnancy?
- Liver tumors (benign or malignant) or active liver disease?
- Uncontrolled hypertension?
- None of the above

Does the patient meet FDA-approved indication? (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)  Yes  No

O09.211 Supervision of pregnancy with history of pre-term labor, first trimester  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_ Description \_\_\_\_\_  
Is the patient currently on compounded HPC (17P)?  Yes  No

**OB History:**

Gravida:  0  1  2  3  Other \_\_\_\_\_  
Para:  0  1  2  3  Other \_\_\_\_\_  
Gestational age of prior preterm birth \_\_\_\_\_ weeks

Has the patient had a previous spontaneous singleton preterm birth (earlier than 37 weeks gestation)?  Yes  No

Has the patient had any previous preterm birth?  Yes  No

If YES, please check indication(s) that apply:

- Multiple gestation  Fetal complications  Incompetent cervix
- Maternal complications—premature rupture of membranes

Additional Comments \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Medication	Dose /Strength	Directions	Quantity	Refills
<input type="checkbox"/> <b>Makena® (17P)</b> (hydroxyprogesterone caproate injection)	250 mg/mL 1 mL Vial	Inject 1 mL IM each week		
<input type="checkbox"/> <b>Makena® auto-injector</b> (hydroxyprogesterone caproate)	275 mg/1.1 mL auto-injector	Inject 1.1 mL (275 mg) SC once weekly		
<input type="checkbox"/> <b>18-g needle &amp; 3mL syringe</b>				
<input type="checkbox"/> <b>21-g, 1 1/2" needle</b>				

Supplies Needed (if medication is to be administered in patient's home): If checked, please specify the size and type is applicable

Syringes/Needles  Swabs  Sharps Container  Other: \_\_\_\_\_

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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