Makena® / Progesterone Prescription

Fax Referral to: 512-487-5033 Phone: 512-432-5190

Electronic Referral to: Lamar Plaza Drug Store

Patient Information		Prescriber Information		
Patient Name		Prescriber Name		
Address		DEA#	NPI#	License #
City, State, Zip		Address		
Primary Phone	Emergency Contact Name & Phone Number	City, State, Zip		
Date of Birth		Phone	Fax	
Social Security #	Insurance ID #	Contact Person	Phone	

Insurance Information: Please fax FRONT and BACK copy of prescription and medical insurance cards.

Diagnosis/Clinical Information: **Please complete clinical criteria section and fax recent clinical notes to expedite the Prior Authorization**

Diagnosis: ☐ O09.219 pregnancy with history of preterm labor. ☐ Other Diagnosis: _____

Does the patient meet the FDA approved indication for Makena - current pregnancy is singleton and patient has a history of singleton spontaneous birth of less than 37 weeks. ☐ Yes ☐ No Current Gestational Age: _____ weeks _____ days Date recorded:

Is the patient currently on compounded HPC ("17P") ? ☐ Yes ☐ No

Previous Preterm delivery of singleton at: 1.) _____ weeks 2.) _____ weeks 3.) _____ weeks Desired Start Date: _____

Allergies: Height: Weight:

Clinical Criteria:

1.) History of thrombosis or thromboembolic disease?	☐ **Yes**	☐ **No**
2.) History of known/suspected breast/horomone sensitive cancer?	☐ **Yes**	☐ **No**
3.) Any undiagnosed vaginal bleeding unrelated to pregnancy?	☐ **Yes**	☐ **No**
4.) Any cholestatic jaundice of current pregnancy?	☐ **Yes**	☐ **No**
5.) History of benign/malignant liver tumor or active liver disease?	☐ **Yes**	☐ **No**
6.) Any uncontrolled hypertension?	☐ **Yes**	☐ **No**

Prescription Information

Rx:	Medication	Dose / Strength	Directions	Quantity	Refills
☐	**Hydroxy-progesterone caproate** (generic Makena®)	250mg/ML 1 ML vial	Inject 1 ML intramuscularly (IM) every 7 days	# 4 Single Dose Vials	_____
☐	**Makena® Auto-Injector** (hydroxyprogesterone caproate)	275mg /1.1ML Auto-Injector	Inject 1.1 ML subcutaneously (SQ) every 7 days	# 4 Auto-Injectors	_____
☐	**Lidocaine Topical Ointment**	5% Ointment	Apply topically every 7 days 1 hour prior to site of Makena injection for pain relief	# 50 gram	_____
☐	**Citranatal Harmony Vitamins**	#30 Tablets	Take 1 tablet by mouth every day	# 30 Tablets	_____

Injection Administrator: ☐ Physician's Office ☐ Patient's Caregiver (trained by Physician's Office) ☐ Other: _____

Please send the prescription to: ☐ Physician's Office ☐ Patient's Home

We include an Administration Kit with each prescription at no additional cost. Or for no kit, please check box: ☐

Please indicate which two needle sizes to include in the kit: ☐ 18 g 1.5" ☐ 21 g 1.5" ☐ 23 g 1.5" ☐ Other: _____

☐ Please indicate for Alcohol Swabs to be included: # 1 month supply ; Refills up to 21 Makena doses. Swab skin inj site & for vial prep every 7 days.

☐	**Progesterone Vaginal Suppository** (compounded)	100mg	Unwrap and insert 1 suppository vaginally every night at bedtime	# 30 Suppositories	_____
☐		200mg			
☐		400mg			
☐	**Crinone® Vaginal Gel** (progesterone gel)	8% Applicator	Unwrap and insert 1 applicatorful vaginally every night at bedtime	# 30 Applicators	_____

Prescriber's Signature (no stamp signature) If Brand required check ☐ DAW Date

By signing this form, you are authorizing Martin's Specialty Pharmacy and its representatives to act as your prior authorization designated agent to work with prescription and medical insurance companies to initiate and execute the process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.