



Makena is available upon Prior Approval through Envision, please call 855-872-0005 before ordering Makena from Exactus and using this Makena Referral Prescription Form

STEP 1 – Complete Patient and Insurance Information (REQUIRED; please include copies of front and back of insurance cards)

First Name:	Last Name:	MI:	Prescription Drug Insurer: Virginia Premier Health Plan	
Address:			PBM: EnvisionRxOptions	BIN#: 009893
Date of Birth:	Known Allergies:		ID#:	
Phone #:	Best Time to Contact:		Group#: V7HA	

STEP 2 – Patient Eligibility (REQUIRED)

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	<u>Current Gestational Age:</u>	Currently on 17P? ☐ Yes ☐ No
	Weeks: _____ Days: _____	
	Date Recorded: _____ MM/DD/YYYY	

STEP 3 – Complete and Sign Makena Rx (REQUIRED)

Prescriber Name (Last, First):	Specialty:	NPI #:	
Address:		Medicaid Provider #:	
Practice Name:	Office Phone:	Office Fax:	
Office Contact(s):	Direct Phone:	AFTER HOURS. Phone:	Email

Rx: Makena (hydroxyprogesterone caproate injection) 250 mg/mL, 5mL multi-dose vial

☐ Dispense 1 vial, followed by _____ refills for a complete course of therapy Sig: Inject 1 mL IM each week

<u>Preferred Injection Setting:</u> ☐ Healthcare Provider ☐ Home via home health provider (if approved by patient's insurer)	<u>Please ship Makena to:</u> ☐ Prescriber ☐ Patient	<u>Ancillary Supplies:</u> ☐ 18-g needle & 3 mL syringe, # _____ ☐ 21-g, 1.5" needle # _____
<u>I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.</u>		Anticipated Start Date: _____ MM/DD/YYYY

Prescriber's Signature: _____ Date: _____



FAX TO 866-458-9240