MAKENA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ❑ Brand ❑ Generic	**Dosage:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	**If ongoing, provide date started:**	**If medication is ongoing, Did member show improvement while on therapy?**	❑Yes ❑No
Diagnosis:		**Date of Diagnosis:**	

MEDICAL HISTORY

Does the member have a diagnosis of singleton pregnancy?	❑ Yes ❑ No
Does the member have a prior history of singleton spontaneous preterm birth?	❑ Yes ❑ No
Has the member previously tried a compounded hydroxyprogesterone formulation?	❑ Yes ❑ No

Does the member have a history of the following? (*Select all that apply*)

- ❑ Current or history of thrombosis or thromboembolic disorder
- ❑ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
- ❑ Known or suspected breast cancer
- ❑ Cholestatic jaundice of pregnancy
- ❑ History of hormone sensitive cancer
- ❑ Uncontrolled hypertension
- ❑ Liver tumors or active liver disease

HISTORY OF PREVIOUS MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Name	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

Please provide any additional information which should be considered in the space below: