317 Nassau Blvd, Garden City, NY 11530
T-516-292-7788 F-516-292-5103
Specialty@AmericarePS.com

Makena Referral

Patient Name	
Address	
City, St, Zip	
Primary Phone	
Alternate Phone	
Email	
Primary Language	
Drug Allergies	
Date of Birth	
Emergency Contact	

Practice Name	
Prescriber Name	
Office Contact	
Office Contact Email	
Phone Number	
Fax Number	
Practice Address	
City, St, Zip	
Prescriber NPI	
Today's Date	

Medicaid ID # _____ HMO Name_____ HMO ID # _____

1.What is the intended use?
☐Reduce risk and/or prevent preterm birth
☐Other_____

2.Is the patient an asymptomatic pregnant woman? ☐Yes ☐No

3.Is this a singleton pregnancy? ☐Yes ☐No

4.Is the patient currently receiving Makena? ☐Yes ☐No

5.When is the patient planned to begin treatment with Makena?
Gestational age: _____weeks _____days

6.What is the planned duration of treatment? _____weeks of gestation

7.Is the patient currently receiving compounded HCP ("17P")? ☐Yes ☐No

8.Was the previous birth a singleton pregnancy? ☐Yes ☐No

9.What is the current gestational age? _____weeks _____ days
Date recorded:_____

10.ICD 10 Code
☐O09.212 Supervision of pregnancy with history of preterm labor, second trimester
☐O09.213 Supervision of pregnancy with history of preterm labor, third trimester

11.Has the patient had a previous spontaneous singleton preterm birth, defined as delivery at less than 37 weeks gestation following spontaneous preterm labor or premature rupture of membrane? ☐Yes ☐No

12.Does the patient have **ANY** of the following *contraindications* to therapy?
☐Current or history of thrombosis or thromboembolic disorders
☐Known or suspected breast cancer, other hormone-sensitive cancer or a history of these conditions
☐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

13.Does the patient currently *have* **ANY** of the following conditions?
☐Singletons without prior spontaneous preterm birth and short cervix (cervical length less than 2cm/20mm by transvaginal ultrasound)
☐Multiple gestations
☐Symptomatic preterm labor (PROM)
☐Malignant neoplasm of endometrium (ICD10: C54.1)
☐Calculus of kidney and ureter (ICD10: N20-x)
☐Absent, scanty, and rare menstruation (ICD10: N91+)
☐Other abnormal uterine and vaginal bleeding (ICD10: N93+)
☐None of the above

14.Makena (hydroxyprogesterone caproate injection) 250mg/ml (J1725)
Dispense 4 single-dose vials per fill (must send Rx)
☐IM: Inject 1ml IM once weekly ☐SQ: Inject 1.1 ml SQ once weekly

15. Deliver to:
☐Clinic listed above or if different: _____
☐Patient home (must select *one* option below)
☐Patient to bring to clinic for prescriber to administer
☐Homecare already arranged with the following homecare agency_____
☐Pharmacy to arrange homecare with available agency

MUST SEND ELECTRONIC RX, FAX OFFICIAL NYS PRESCRIPTION FORM (WITH BARCODE) ,OR CALL IN RX TO US

I have chosen Americare Pharmaceutical Services Inc. NPI 1679678049, and its employees as an Authorized Agent to assist my staff in handling many of the responsibilities associated with fulfilling the medication requirements of my patients, including specialty medications. These responsibilities include but are not limited to, requesting Prior Authorizations for my patients, answering the criteria questions for the coverage determination within the Prior Authorization Request forms, receiving the Prior Authorization determination from PBMs, as well as any other duties or requirements needed to properly perform a Prior Authorization for my patients. As my Authorized Agent, Americare Pharmaceutical Services, Inc. has been provided all of the required information to accurately complete Prior Authorizations.

MD/Prescriber Signature _____ Date _____