17 alpha-hydroxprogesterone caproate (17P)
Request Form

First Name | Last Name | DOB (M M - D D - Y Y)

Street Address | City

State | Zip Code | Primary Phone#

Current Gestational Age: week(s) | days (0) | Date Recorded: (M M - D D - Y Y)

Patient meets 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

Reason for preterm labor or preterm delivery: _____

_____

Complete and Sign Rx: _____

Prescriber's Name _____

Practice Name _____

Address _____

City _____ State _____ Zip _____

Office Phone# _____ Office Fax# _____

Group NPI# _____ Office Tax ID # _____

Medicaid Provider # _____

Primary Office Contact _____ Direct Phone # _____

After-hours Phone # _____

Email _____

Preferred Method of Communication ○ Phone ○ Fax ○ Email

Is the patient currently receiving 17P? ○ Yes ○ No

IDC-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
- ○ O09.219 -Supervision of pregnancy with history of preterm labor, unspecified trimester

Rx:

- ○ Makena® (hydroxyprogesterone caproate injection) Subcutaneous Auto-Injector
- ○ Hydroxyprogesterone Caproate Injection 250 mg/mL (J1725)
- ○ Compounded 17p

- ○ Dispense 4 x 1 mL single-dose, preservative-free vials (64011-247-02) X _____ refills
- ○ Sig: Inject 1 mL IM each week

- ○ 18-g needles & 3 mL syringe _____ #
- ○ 21-g 1 1/2 needle _____ #

Is the patient on strict bedrest? ○ Yes ○ No

Preferred Injection Setting:

- ○ Healthcare Provider Office
- ○ Home Setting / Self Administered
- ○ Home Health Care Agency, if approved by insurance: _____

Please Ship To:

- ○ Prescriber
- ○ Patient

Desired Start Date: (M M - D D - Y Y) Desired End Date: (M M - D D - Y Y)

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

Prescriber's Signature _____ Date: (M M - D D - Y Y)

For MCO Use Only:

☐ Approved ☐ Denied Current MCO _____ Medicaid/Insurance ID# _____

Number of Injections

Authorization# _____

Date of Notification to Provider (M M - D D - Y Y)

Reviewer Name and Title _____

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