Makena® (hydroxyprogesterone caproate) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **OB/GYN** ☐ **Reproductive Endocrinologist** ☐ **Medical Endocrinologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Makena (brand name) or** ☐ **generic hydroxyprogesterone caproate**
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

CURRENT PREGNANCY: Current gestational age: ____ weeks ____ days Date Recorded: ____/____/____
At what gestational age will the requested drug be started? ____ weeks ____ days

☐ Yes ☐ No Is the requested medication being prescribed to reduce the risk of preterm birth?
☐ Yes ☐ No Is this a singleton pregnancy (patient is currently pregnant with only one baby)?
☐ Yes ☐ No Has the patient had a previous spontaneous preterm birth (defined as delivery at less than 37 weeks gestation following preterm labor, preterm rupture of membranes, and cervical insufficiency)?
→ Please provide the gestational age of prior preterm birth: ____ weeks
☐ Yes ☐ No Was the previous preterm birth also a singleton pregnancy (patient was pregnant with only one baby)?
☐ Yes ☐ No Does the patient have any of the following contraindications to the use of the requested medication (please select all that apply)?
→ ☐ Current or history of thrombosis or thromboembolic disorders ☐ Known or suspected breast cancer
☐ Other hormone-sensitive cancer ☐ History of hormone sensitive cancer ☐ Cholestatic jaundice of pregnancy
☐ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy ☐ Uncontrolled hypertension
☐ Liver tumors, benign or malignant, or active liver disease

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required)***: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.