Cigna®

Fax completed form to: (855) 840-1678

Makena
Hydroxyprogesterone

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Medication Requested

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

☐ J1726 hydroxyprogesterone caproate 250mg/ml vial (generic for Makena / Makena PF)	**Directions:** ☐ Inject 250mg (1ml) IM QW ☐ Other (please specify):	**Quantity/Refills** Total number of doses needed:_____
☐ J1726 Makena (hydroxyprogesterone) 250mg/ml vial	**Directions:** ☐ Inject 250mg (1ml) IM QW ☐ Other (please specify):	**Quantity/Refills** Total number of doses needed:_____
☐ J1726 Makena (hydroxyprogesterone) 275mg/1.1ml Autoinjector	**Directions:** ☐ Inject 275 mg/1.1 mL SQ QW ☐ Other (please specify):	**Quantity/Refills** Total number of doses needed:_____

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Unless noted below, the medication will be delivered directly to the patient by Cigna Home Delivery Pharmacy.
☐ will be administered weekly by Alere/Optum OB home health services
☐ will be administered weekly in my office
☐ other

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information ICD10:

Is Makena being used to reduce the risk of recurrent preterm birth? ☐ Yes ☐ No (please specify reason for use):

Do either of the following apply to your patient?
☐ Pregnancy with cervical insufficiency and/or cerclage in place
☐ Pregnancy with short cervix determined by transvaginal ultrasound
☐ Using for infertility
☐ None of the above

Was the previous preterm birth a singleton pregnancy? Yes ☐ No ☐
Was the previous preterm birth between 20 weeks, 0 days gestation and 36 weeks and 6 days gestation? Yes ☐ No ☐

What was the gestational age (in weeks and days) at the time of this previous preterm birth? _____

Which applies to the previous singleton preterm birth?
☐ spontaneous preterm labor
☐ spontaneous preterm rupture of membranes
☐ neither of the above
Is the current pregnancy a singleton pregnancy? Yes ☐ No ☐

What is the patient's due date? _____

Is this a new start or continuation of therapy with Makena? ☐ new start ☐ continued therapy
(if new start) What will be the gestational age (in weeks and days) when therapy is started? _____

(if continued therapy) What was the gestational age (in weeks and days) when therapy was started? _____

Which drug is being requested?
☐ hydroxyprogesterone caproate injection (generic for Makena/Makena PF)
☐ Brand Makena 250mg/ml
☐ Brand Makena 250mg/1.1ml

(if brand Makena 250mg/ml) For the generic drug, hydroxyprogesterone caproate intramuscular injection, which of the following applies to your patient?

☐ Patient has not tried the generic drug.
☐ Patient tried the generic drug, but it didn't work or didn't work well enough.
☐ Patient tried the generic drug, but had an allergic or adverse reaction.
☐ Other

(if tried, but had a reaction) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the brand and generic products (for example, difference in dyes, fillers, preservatives)?
Yes ☐ No ☐

(if yes) Please provide details to support. _____

(if brand Makena 275mg/1.1ml) Did your patient try hydroxyprogesterone caproate intramuscular injection (generic for Makena / Makena PF intramuscular injection) and have documented significant intolerance to it? Yes ☐ No ☐

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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