17 Alpha Hydroxyprogesterone

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

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)

	Directions:	Quantity/Refills
☐ J1726 hydroxyprogesterone caproate 250mg/ml vial (generic for Makena / Makena PF)	☐ Inject 250mg (1ml) IM QW ☐ Other (please specify):	Total number of doses needed:_________
☐ J1726 Makena (17 alpha-hydroxyprogesterone) 250mg/ml vial	☐ Inject 250mg (1ml) IM QW ☐ Other (please specify):	Total number of doses needed:_________
☐ J1726 Makena (17 alpha-hydroxyprogesterone) 275mg/1.1ml Autoinjector	☐ Inject 275 mg/1.1 mL SQ QW ☐ Other (please specify):	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):

Do either of the following apply to your patient?
☐ cervical insufficiency and/or cerclage in place
☐ short cervix determined by transvaginal ultrasound
☐ neither of the above

Was the previous preterm birth a singleton pregnancy? Yes ☐ No ☐
Was the previous preterm birth between 20 weeks 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)
☐ Makena/Makena PF (brand name)

(if brand Makena / Makena PF) Did your patient try and have a documented intolerance to hydroxyprogesterone caproate injection (generic for Makena/Makena PF)? Yes ☐ No ☐
(if yes) Please explain the intolerance and provide details of the hydroxyprogesterone caproate injection (generic Makena/Makena PF) use (dates, strength, etc). _____________

(if no) Is your patient UNABLE to obtain hydroxyprogesterone caproate injection (generic for Makena/Makena PF)? 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:**______________________

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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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