

Makena[®]

hydroxyprogesterone caproate injection

Ph: 806-324-5447 • Toll Free 866-629-6779
Toll Free Fax: 866-217-8034
Email: specialty@maxor.com
www.maxorspecialty.com

MAXOR[®] SPECIALTY

PATIENT INFORMATION	PHYSICIAN INFORMATION
Patient Name _____ Date of Birth _____ <input type="radio"/> Male <input type="radio"/> Female Street Address _____ Apt # _____ City _____ State _____ Zip _____ Phone-Primary _____ Secondary _____ <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____ Email Address _____ Social Security # _____ <input type="radio"/> NKDA Known Drug Allergies _____ Weight _____ kg/lb Height _____ in/cm Please attach front and back of patient's insurance cards	Physician Name _____ NPI _____ License # _____ Office Contact _____ Street Address _____ Ste # _____ City _____ State _____ Zip _____ Phone _____ Fax _____ By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient. Physician Signature _____ Date _____ <input type="radio"/> Dispense as written <input type="radio"/> Product substitution permitted ** For Ohio patients, please only choose one (1) prescription/form.**

CLINICAL INFORMATION

Does the patient meet FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)? Please see full prescribing information.

Yes No

Current Gestational Age: _____ weeks _____ days Date recorded: _____

Is the patient currently receiving Makena? Yes No

Is the patient currently receiving compounded HPC ("17P")? Yes No

ICD-10 Code:

009.212 Supervision of pregnancy with history of preterm labor, second trimester

009.213 Supervision of pregnancy with history of preterm labor, third trimester

009.219 Supervision of pregnancy with history of preterm labor, unspecified trimester

Other: _____

PRESCRIPTION INFORMATION **CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM**

RX: Makena (hydroxyprogesterone caproate injection) 250mg/ml (J1725)
Inject 250mg (1ml) intramuscularly every 7 days

Dispense 4 X 1 ml single-dose, preservative-free vials (64011-0247-02) X _____ refills

Dispense 1 vial Makena 1250mg/5ml multi dose vial (64011-0243-01) X _____ refills

18G needle and 3ml syringe # _____

21G 1 ½ " needle # _____

Preferred Injection Setting:

Healthcare Provider Office - Send to Central Fill Floorstock Pharmacy

Makena @ Home _____, if approved by insurance

Date Meds Needed: _____ New Refill

Ship to: Patient's home

Physician's Office: Arlington HCW-Main HCS-NW NEC

Poly South Campus Viola Pitts

Other _____