P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Makena™

(hydroxyprogesterone caproate, 17P)

Therapeutic use: Prevention of preterm birth
Quantity Limit: 250 mg (1 mL) once weekly up to 37 weeks of gestation
Authorization Period: maximum of 21 weeks of therapy

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient's current pregnancy a singleton pregnancy?	❑ Yes	❑ No
2.	Does the patient have a history of singleton spontaneous preterm birth?	❑ Yes	❑ No
3.	Has the patient tried and failed compounded 17P?	❑ Yes	❑ No
4.	What is the current gestational age? _____ weeks _____ days		

Compounded 17P is available through Intermountain Homecare and does not require preauthorization

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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