Prescription & Enrollment Form

Women's Health

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's name ______________________

Date of birth ____________ ❑ Male ❑ Female Last 4 digits of SSN __________

Street address ______________________ Apt # ________

City ______________________ State ______ Zip __________

Parent/guardian (if applicable) ______________________

Home phone ______________________

Work phone ______________________

Cell phone ______________________

Evening phone ______________________

E-mail address ______________________

Patient's primary language: ❑ English ❑ Other

If other, please specify ______________________

Please attach front and back of patient's insurance cards or complete information below.

Insurance company ______________________

Phone ______________________

Insured's name ______________________

Insured's employer ______________________

Relationship to patient ______________________

Identification # ______________________

Policy/group # ______________________

Prescription card: ❑ Yes ❑ No If yes, carrier ______________________

Policy # ______________________

Group # ______________________

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ____________ Time __________ Date medication needed ____________

Prescriber's name and title ______________________

If NP or PA, under direction of Dr. ______________________

Office contact and title ______________________

Clinic/hospital affiliation ______________________

Street address ______________________ Suite # ________

City ______________________ State ______ Zip __________

Phone ______________________ Fax ______________________

NPI # ______________________ License # ______________________

Preferred injection setting: ❑ Healthcare provider office

❑ Makena @ Home, if approved by insurance

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Desired start date ____________

Clinic location ______________________

3 CLINICAL INFORMATION

Primary 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 ______________________

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)? ❑ Yes ❑ No

Current gestational age _____ weeks______ days________ Date recorded ____________

Is the patient currently receiving Makena® (hydroxyprogesterone caproate injection)? ❑ Yes ❑ No

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

Please indicate if there is current or history of:

❑ Thrombosis or thromboembolic disorders

❑ Known or suspected breast cancer and/or other hormone-sensitive cancers

❑ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy

❑ Cholestatic jaundice of pregnancy

❑ Liver tumors, benign or malignant, or active liver disease

❑ Uncontrolled hypertension

❑ NKDA ❑ Known drug allergies ______________________

Concurrent meds ______________________

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ hydroxyprogesterone caproate injection	250 mg/mL 1 mL SDV	Inject 1 mL Intramuscularly each week (every 7 days)	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ________
❑ Makena® (hydroxyprogesterone caproate injection)	275 mg/1.1 mL Autoinjector	Inject 1.1 mL under the skin via autoinjector each week (every 7 days)	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ________
❑ Other			Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ________
❑ Single dose kit for IM administration		Dispense dose kit to administer medication	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ Refills ________

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. If brand name product is required please specify the brand name drug product.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

____________ ______________________ ____________ ______________________

Date Substitution allowed Date Dispense as written

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your drug therapy team at 888.302.1028.

To reach your team, call toll-free 866.880.2283 option 2.

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