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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