

# Makena® Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: customerservicefax@caremark.com

Phone: 1-800-237-2767

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to: ☐ Patient ☐ Office ☐ Other: \_\_\_\_\_

#### Supplies:

☐ 18-g needle and 3 mL syringe \_\_\_\_\_ # X \_\_\_\_\_ refills

☐ 21-g, 1 1/2 needle \_\_\_\_\_ # X \_\_\_\_\_ refills

#### Diagnosis (ICD-10):

☐ O09.212 Supervision of pregnancy with history of preterm labor, second trimester

☐ O09.213 Supervision of pregnancy with history of preterm labor, third trimester

☐ O09.219 Supervision of pregnancy with history of preterm labor, unspecified trimester

☐ O60.00 Preterm labor without delivery, unspecified trimester

☐ Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us)

<https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us>

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm Gestational Age: \_\_\_\_\_ weeks

#### Nursing:

☐ Pharmacy to coordinate home health nursing for administration

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Makena Intramuscular Injection	250 mg/mL	Inject 1 mL IM each week.	Quantity: 4 x 1 mL single-dose, preservative-free vials Refills: _____
<input type="checkbox"/> Makena Subcutaneous Auto-Injector	275 mg/1.1mL	Inject 1.1 mL SC via auto-injector each week.	Quantity: 4 x 1 mL single-dose, pre-filled SC auto-injectors Refills: _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

### 6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_ X \_\_\_\_\_

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

©2018 CVS Specialty and/or one of its affiliates. 75-40777A 101018