

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**MAKENA, or compounded  
HYDROXYPROGESTERONE CAPROATE (17-p)**

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_  
Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992 note the new fax number**

**CRITERIA:**

- Approved for the prevention of preterm labor for patients with prior history of preterm delivery.
- Must be prescribed by OBGYN.
- Therapy initiated between weeks 16-23 of gestation.
- The patient must not be in active labor at the time of administration.

**NOTES:**

- If commercially available Makena is requested, the provider must submit justification for using the commercial product in lieu of the compounded product; for example, details of adverse reaction, allergy or inadequate response to the compounded product
- This Prior Authorization is only available to clients enrolled in Traditional Medicaid (Purple Card).

**AUTHORIZATION:**

For duration of the pregnancy

**RE-AUTHORIZATION:**

Same as initial

04/04/2011