HIGHMARK HEALTH OPTIONS

Updated: 05/2022
DMMA Approved: 06/2022

Request for Prior Authorization for Makena (hydroxyprogesterone caproate injection)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Makena (hydroxyprogesterone caproate injection) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Makena (hydroxyprogesterone caproate injection) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of prophylaxis of preterm birth and the following criteria is met:

- Member must be 16 years of age or older
- Must have a singleton pregnancy (i.e. one fetus)
- Must have a history of singleton spontaneous preterm birth defined as delivery prior to 37 weeks gestation
- The pregnancy is between 16 weeks, 0 days and 20 weeks, 6 days gestation
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member must not have any of the following contraindications to Makena:
    - Current or history of thrombosis or thromboembolic disorders
    - Known or suspected breast cancer, other hormone-sensitive cancer, or history of these conditions
    - Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
    - Cholestatic jaundice of pregnancy
    - Liver tumors, benign or malignant, or active liver disease
    - Uncontrolled hypertension
- **Initial Duration of Approval:** coverage is provided until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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MAKENA (HYDROXYPROGESTERONE CAPROATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication (check desired formulation below):

- ☐ Makena 1250mg/5mL Injection
- ☐ Makena 250mg/1ml Vials
- ☐ Makena 275mg/1.1ml Auto-Injector

Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?
☐ Yes ☐ No

BILLING INFORMATION

This medication will be billed: ☐ at a pharmacy OR ☐ medically, JCODE:_____

Place of service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

PLACE OF SERVICE INFORMATION

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY

Is the current pregnancy singleton (i.e., one fetus)? ☐ Yes ☐ No

Current Estimated Gestational Age: _____
Estimated Delivery Date: _____

Is Makena being prescribed for the prevention of preterm singleton birth? ☐ Yes ☐ No

Previous singleton spontaneous preterm delivery (SPTD): Date_____ Gestational age weeks: _____ days _____

Does the member have a history of spontaneous preterm birth (delivery prior to 37 weeks gestation)? ☐ Yes ☐ No

Does the member have any contraindications to starting therapy with Makena? ☐ Yes ☐ No

Anticipated Start Date:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature:	**Date:**