



**Hydroxyprogesterone Caproate (Makena®)
Injectable Medication Precertification Request**

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy **Today's date:** _____ **Date needed:** _____

Dispensing Provider for Medication Request: Aetna Specialty Pharmacy® or Other _____
Phone: _____ Fax: _____ TIN: _____ PIN: _____

If ASRx is dispensing, ship to: Doctor's office Patient Other: _____ Phone: _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State: ZIP:
Phone:	Fax:	St. Lic. #:	NPI #: DEA #: UPIN:
Provider Email:		Office Contact Name: Phone:	
Specialty (Circle one): Ob/Gyn Reproductive Endocrinologist Medical Endocrinologist Other: _____			

D. DIAGNOSIS INFORMATION

Primary ICD-9: _____
Secondary ICD-9: _____ Other ICD-9 Code: _____

E. CLINICAL INFORMATION – Please complete in entirety.

<p>CURRENT PREGNANCY:</p> <p>Current Gestational Age: _____ weeks _____ days</p> <p>Date Recorded: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient pregnant with a singleton?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient experiencing preterm labor?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a cerclage?</p> <p>Where will the Medication be administered? <input type="checkbox"/> Office <input type="checkbox"/> Home</p> <p>If Home, please list CPT code requested _____</p>	<p>OB HISTORY:</p> <p>Gravida: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____</p> <p>Para: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____</p> <p>Gestational Age of prior preterm birth: _____ weeks</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a previous spontaneous singleton preterm birth (earlier than 37 weeks gestation)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had any previous preterm birth?</p> <p>If yes, please check indication(s) that apply:</p> <p><input type="checkbox"/> Multiple gestation <input type="checkbox"/> Maternal complications</p> <p><input type="checkbox"/> Fetal complications <input type="checkbox"/> Incompetent cervix</p>
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F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Makena® CPB # 0510				

*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
*If the prescriber is providing the drug, the provider must verify benefits.

Prescriber's Signature: _____ **Date:** ____ / ____ / ____

(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space: _____