Americare PS™
PHARMACEUTICAL SERVICES

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Specialty@AmericarePS.com

Makena referral

Patient Name	
Address	
City, St, Zip	
Primary Phone	
Alternate Phone	
Email	
Primary Language	
Drug Allergies	
Gender	
Date of Birth	

Practice Name	
Prescriber Name	
Office Contact	
Office Contact Email	
Phone Number	
Fax Number	
Practice Address	
City, St, Zip	
Prescriber NPI	
Today's Date	

Medicaid ID # _________________________ HMO Name_________________________ HMO ID # _________________________

1.What is the intended use?
☐Reduce risk and/or prevent preterm birth
☐Other___________________________

2.Is the patient an asymptomatic pregnant woman? ☐Yes ☐No

3.Is this a singleton pregnancy? ☐Yes ☐No

4.Is the patient currently receiving Makena? ☐Yes ☐No

5.When is the patient planned to begin treatment with Makena?
Gestational age: _________weeks ________days

6.What is the planned duration of treatment? ________weeks of gestation

7.Is the patient currently receiving compounded HCP ("17P")? ☐Yes ☐No

8.Was the previous birth a singleton pregnancy? ☐Yes ☐No

9.What is the current gestational age? _________weeks ________ days
Date recorded:________________

10.ICD 10 Code
☐O09.212 Supervision of pregnancy with history of preterm labor, second trimester
☐O09.213 Supervision of pregnancy with history of preterm labor, third trimester

11.Has the patient had a previous spontaneous singleton preterm birth, defined as delivery at less than 37 weeks gestation following spontaneous preterm labor or premature rupture of membrane? ☐Yes ☐No

12.Does the patient have **ANY** of the following *contraindications* to therapy?
☐Current or history of thrombosis or thromboembolic disorders
☐Known or suspected breast cancer, other hormone-sensitive cancer or a 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
☐None of the above

13.Does the patient currently *have* **ANY** of the following conditions?
☐Singletons without prior spontaneous preterm birth and short cervix (cervical length less than 2cm/20mm by transvaginal ultrasound)
☐Multiple gestations
☐Symptomatic preterm labor (PROM)
☐Malignant neoplasm of endometrium (ICD10: C54.1)
☐Calculus of kidney and ureter (ICD10: N20-x)
☐Absent, scanty, and rare menstruation (ICD10: N91+)
☐Other abnormal uterine and vaginal bleeding (ICD10: N93+)
☐None of the above

14.Makena (hydroxyprogesterone caproate injection) 250mg/ml (J1725)
Dispense 4 X 1ml single-dose, preservative-free vials _____refills
☐IM: Inject 1ml IM once weekly (must send Rx-see note below)
☐SQ: Inject 1ml SQ once weekly (must send Rx-see note below)

15. Pharmacy to coordinate home administration with:
☐Archcare at Home (Dominican Sisters)
☐Other/no preference ______________
(may require additional paperwork)

☐Deliver to office
☐Deliver to patient home for office administration

MUST SEND ELECTRONIC RX, FAX OFFICIAL NYS PRESCRIPTION FORM (WITH BARCODE) ,OR CALL IN RX TO US

I have chosen Americare Pharmaceutical Services Inc. NPI 1679678049, and its employees as an Authorized Agent to assist my staff in handling many of the responsibilities associated with fulfilling the medication requirements of my patients, including specialty medications. These responsibilities include but are not limited to, requesting Prior Authorizations for my patients, answering the criteria questions for the coverage determination within the Prior Authorization Request forms, receiving the Prior Authorization determination from PBMs, as well as any other duties or requirements needed to properly perform a Prior Authorization for my patients. As my Authorized Agent, Americare Pharmaceutical Services, Inc. has been provided all of the required information to accurately complete Prior Authorizations.

MD/Prescriber Signature ____ Date ______________________________