# Makena Enrollment Form

CVS specialty®

**Fax Referral To:** 1-800-323-2445
**Email Referral To:** Customer.ServiceFax@CVSHealth.com

**Phone:** 1-800-237-2767

**Six Simple Steps to Submitting a Referral**

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

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
**Relationship to minor**: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

## 2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
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 ½ 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 _____

**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 |
|---|---|---|---|
| ☐ Makena Intramuscular Injection | 250 mg/mL | Inject 1 mL IM each week. | Quantity:<br>4 x 1 mL single-dose, preservative-free vials<br>Refills: _____ |
| ☐ Makena Subcutaneous Auto-Injector | 275 mg/1.1mL | Inject 1.1 mL SC via auto-injector each week. | Quantity:<br>4 x 1 mL single-dose, pre-filled SC auto-injectors<br>Refills: _____ |
| ☐ Other: _____ | Other:_____ | Other: _____ | Quantity: _____<br>Refills: _____ |

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

## 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
**Prescriber's Signature: _____Date: _____**

May Substitute / Product Selection Permitted / Substitution Permissible
**Prescriber's Signature: _____Date: _____**

**CA, MA, NC & PR**: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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 above, 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.