Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Makena® (17P alpha hydroxyprogesterone)

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Makena® (17P alpha hydroxyprogesterone). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	**Member ID Number:** (required)
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)

Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) ( ) -	**Office Fax Number:** (required) ( ) -

Directions of use: ____

Quantity______ **Duration of Treatment** _______________

Please answer all questions below

	YES	NO
Is patient pregnant and had a prior liveborn, single pregnancy of less than 37 weeks resulting from a spontaneous preterm delivery or spontaneous rupture of membranes?	☐	☐
Does patient have a multiple gestation with this pregnancy?	☐	☐
Does patient have known fetal anomaly?	☐	☐
Does patient have current or planned cervical cerclage?	☐	☐
Does patient have hypertension requiring medication?	☐	☐
Does patient have seizure disorder?	☐	☐

BENEFIT TERMS UPON APPROVAL:

Initial approval will be for up to 21injections

All information provided on this form is accurate as of this date.

Provider Signature:_________________________NPI_______________ **Date:**______________

Completed forms should be faxed to: Customer Service Department (866) 423-0945