Specialty Prescription Form

1. PATIENT INFORMATION

Patient Name ______
Address ______
Apt. ______
City, State, ZIP ______
Home Phone ______ Alternate Phone ______
DOB ______
Language Preference: ◯ English ◯ Spanish ◯ Other ______

2. PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Prescription Card: Name of Insurer ______ ID # ______ BIN ______ PCN ______ Group ______

Primary Insurance: Subscriber ______ ID # ______ Name of Insurer ______ Phone ______

Secondary Insurance: Subscriber ______ ID # ______ Name of Insurer ______ Phone ______

4. DIAGNOSIS AND CLINICAL INFORMATION

Current Pregnancy:

Current gestational age: ______ weeks ______ days

Date recorded: ___/___/______

Is this a singleton pregnancy? ◯ Yes ◯ No

Please select all that apply:

- ◯ Known, suspected, or history of breast cancer or other hormone sensitive cancer
- ◯ Current or history of thrombosis or thromboembolic disorders
- ◯ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
- ◯ Choleostatic jaundice or pregnancy
- ◯ Liver tumors (benign or malignant)
- ◯ Active liver disease
- ◯ Uncontrolled hypertension
- ◯ None of the above

Diagnosis:

◯ OØ9.211 - Supervision of pregancy with history of preterm labor, first trimester
◯ Other diagnosis: ICD-10 Code: ______ Descript: ______

Is the patient currently on Makena or 17-hydroxyprogesterone? ◯ Yes ◯ No

Please list all current medications: ______

Please list all known drug allergies: ______

OB History:

Gestational age of prior pre-term birth: ______ weeks

Has the patient had a previous spontaneous singleton pre-term birth earlier than 37 weeks gestation? ◯ Yes ◯ No

If so, check indication(s) that apply:

◯ Multiple gestation ◯ Fetal complications ◯ Incompetent cervix
◯ Premature rupture of membranes

5. PRESCRIPTION INFORMATION- *Ancillary supplies and kits will be provided as needed for administration.*

Medication	Dose/Strength	Directions	Quantity	Refills
◯ **hydroxyprogesterone caproate**	250mg/1ml	Inject 1ml intramuscularly every week	#4x1ml vials	

Ship to: ◯ Office ◯ Patient

Home health: ◯ **Yes** - Optum Phone: 800-999-2415 Fax:800-867-2872 Initiate Optum home care services: Weekly visit with maternal/fetal assessment and Makena administration ◯ **No**

6. PRESCRIBER SIGNATURE - *stamped signatures are **NOT** permitted*

X ______ / /
DISPENSE AS WRITTEN DATE

X ______ / /
PRODUCT SUBSTITUTION PERMITTED DATE

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