

# 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
- ☐ Cholestatic jaundice or pregnancy
- ☐ Liver tumors (benign or malignant)
- ☐ Active liver disease
- ☐ Uncontrolled hypertension
- ☐ None of the above

### Diagnosis:

☐ O09.211 - Supervision of pregnancy 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

**Ship to:** ☐ Office ☐ Patient

**Home health:** ☐ Yes - Optum

Phone: 800-950-3963  
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 \_\_\_\_\_ / / X \_\_\_\_\_ / /  
DISPENSE AS WRITTEN DATE PRODUCT SUBSTITUTION PERMITTED DATE

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