

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:

OØ9.211 - 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: 800-999-2415
 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

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law.

If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.