Makena
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for Makena to meet criteria confirming the medication is being used according to its FDA-approved indication. Please fill out the following form in its entirety.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	
Member's Estimated Date of Delivery or Gestational Age of Current Pregnancy (weeks and days):		
Does the member have a history of singleton spontaneous preterm birth? ☐ YES ☐ NO		
Is the member currently pregnant with singleton? ☐ YES ☐ NO		
The U.S. FDA Center for Drug Evaluation and Research proposed that Makena be withdrawn from market after a required post-market study failed to show clinical benefit or efficacy for its approved use. Considering the U.S. FDA proposal for withdrawal of this agent, does the prescriber acknowledge the FDA request to remove Makena from market and deem it medically necessary to use anyway? ☐ YES ☐ NO		
Clinical rationale for using this agent is <u>required</u> for coverage:		
☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*		
Prescriber (or Staff) / Pharmacy Signature**		Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*		

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #