



**Makena
Prior Authorization Form**

<p align="center">Fax Completed Form to: 855-207-0250 For questions regarding this Prior authorization, call 866-773-0695</p>
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Prior Authorization Vendor for ND

ND Medicaid requires that patients 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 PHYSICIAN

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name		Specialist involved in therapy (if not treating physician)			
Prescriber NPI		Telephone Number		Fax Number	
Address		City		State	Zip Code
Requested Drug and Dosage:			Diagnosis for this request:		
Patient's Estimated Date of Delivery or Gestational Age of Current Pregnancy (weeks and days):					
Does the patient have a history of singleton spontaneous preterm birth? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Is the patient currently pregnant with singleton? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Additional Qualifications for Coverage (if applicable)					
<input type="checkbox"/> 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 patient'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 #		