CoxHealth at Home

Springfield
2240 W. Sunset, Ste. 104
Springfield, MO 65807

Cape Girardeau
286 Christine Street
Cape Girardeau, MO 63703
Ph: (573) 332-1955 Fax: (573) 332-1976

Makena Enrollment Form

PHONE: **1-855-419-4663** FAX: **1-417-269-0692**

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ /____ / ____ ☑ Female SSN: ____ -____ - ____

Address: _____ _____ City: _____ ___ State: _____ Zip: _____ _____

Phone: (____) - ____ - _____ Alternate Phone: (____) - ____ - _____ email: _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Text ☐ Other: _____ Height: _____ in Weight: _____ lb

Allergies:

Medications: (Please attach additional pages if necessary)

PRIMARY PRESCRIPTION BENEFITS PROVIDER

Provider: _____

Phone: (____) - ____ - _____

ID #: _____ Group #: _____

Rx BIN: _____ Rx PCN: _____

(Please fax copy of front and back of card)

SECONDARY PRESCRIPTION BENEFITS PROVIDER

Provider: _____

Phone: (____) - ____ - _____

ID #: _____ Group #: _____

Rx BIN: _____ Rx PCN: _____

(Please fax copy of front and back of card)

PRESCRIBER INFORMATION

Prescriber Name: _____

Office Phone: _____ Fax: _____ Contact: _____

Clinic/Hospital Affiliation: _____

Address: _____ City: _____ State: _____ Zip: _____

License #: _____ NPI #: _____ Medicaid Provider #: _____

CLINICAL INFORMATION

Does the patient meet FDA -approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)? ☐ YES ☐ NO Current Gestational Age: _____ weeks _____days

Is patient currently receiving Makena? ☐ YES ☐ NO

Is patient currently receiving compounded HPC ("17P")? ☐ YES ☐ NO

(patient may start Makena between16 weeks and 20 weeks, 6 days of pregancy)

DIAGNOSIS

☐ ICD-10 O09.219 Pregnancy with a history of preterm labor ☐ Other:

PRESCRIPTION

Medication	Directions for use
☐ Makena (hydroxyprogesterone caproate injection) 275mg/1.1 ml 4x1 autoinjectors _____refills	Inject 1.1mL SQ weekly until week 37 or until delivery, whichever happens first
☐ Hydroxyprogesterone caproate injection 250 mg/ ml, 4 x 1 ml vials _____ refills	Inject 1 mL IM weekly until week 37 or until delivery, whichever happens first

Supplies for IM Injections

CoxHealth at Home will dispense needles and syringes suffcient for number of injections sent

☐ Do not send supplies

By signing below, I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ Date: ____ /____ / ____

PATIENT INJECTION SETTING

☐ Physician/ Clinic ☐ CoxHealth at Home

SHIPPING INFORMATION

Ship to: ☐ Physician/Clinic ☐ Patient Date Shipment Needed By: ____ /____ / ____