State of Oklahoma
Oklahoma Health Care Authority
Prior Authorization Form: Makena® (17-hydroxyprogesterone caproate), Crinone® (progesterone gel), and Endometrin® (progesterone vaginal insert)

Member Name:	SoonerCare ID #:	Date of Birth:
Pharmacy NPI:	Pharmacy Phone:	Pharmacy Fax:
Pharmacy Name:		Pharmacist Name:
Prescriber NPI #:	Prescriber Name:	
Specialty:	Prescriber Phone:	Prescriber Fax:

Medication Requested:

Drug Name:_____ Strength:_____ Dosage:_____ Refills:_____

Start Date:_____ Fill Quantity:_____ Day Supply:_____

If requesting Makena®: **Please note only exact amount of mL required will be approved. If the 5ml vial will be used, please provide NDC's for both the 1ml vial and the 5ml vial. Member may require 1mL vials to achieve exact dosing.**

❑ 1mL vial: **NDC:**_____ ❑ 5mL Vial: **NDC:**_____ ❑ Auto-Injector: **NDC:**_____

If requesting Endometrin® or Crinone®: **NDC:** _____

Criteria

Makena® (17-Hydroxyprogesterone Caproate) Approval Criteria:

1. Documented history of previous singleton spontaneous preterm delivery (SPTD) prior to 37 weeks gestation; and
2. Current singleton pregnancy; and
3. Gestational age between 16 weeks, 0 days and 26 weeks, 6 days gestation.
4. Authorizations will be for once a week administration by a healthcare professional through 36 weeks, 6 days gestation.

Endometrin® (Progesterone Vaginal Insert) and Crinone® (Progesterone Vaginal Gel) Approval Criteria:

1. Current singleton pregnancy; and
2. Member must not have history of previous singleton spontaneous preterm delivery (SPTD); and
3. Cervical length of ≤ 20mm; and
4. Gestational age between 20 weeks, 0 days and 26 weeks, 6 days of gestation; and
5. For those requesting Crinone®: A patient-specific, clinically significant reason why the member cannot use Endometrin®.
6. Authorizations will be given for treatment through 36 weeks, 6 days of gestation.
7. Endometrin® and Crinone® will not be covered for use with assisted reproductive technology (ART) for female infertility.

Clinical Information

1. Does member have a history of previous singleton spontaneous preterm delivery (SPTD): Yes_____ No_____
2. Date and gestational age of previous singleton spontaneous preterm delivery (SPTD):
   _____
3. Current singleton pregnancy: Yes_____ No_____ Date of Ultrasound:_____
4. Gestational age of current pregnancy:_____ Date:_____
5. Estimated delivery date:_____

For Makena® Auto-Injector:

1. Will the initial dose using the Makena® Auto-Injector be administered by a healthcare professional? Yes_____ No_____
2. Has the member/caregiver been trained by a healthcare professional on subcutaneous administration and storage of Makena® Auto-Injector? Yes_____ No_____

For Endometrin® or Crinone®: Member's cervical length :_____ mm

Additional Information or patient-specific, clinically significant reason for use of Crinone® in place of Endometrin®:

_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Prescriber/Pharmacist Signature:_____ **Date:**_____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) *Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4