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®: ❑ 1mL vial: **NDC:**_____ ❑ 5mL Vial*: **NDC:**_____

❑ Auto-Injector: **NDC:**_____

Please note only exact amount of mL required will be approved. Member may require 1mL vials to achieve exact dosing.

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

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