Neighborhood Health Plan OF RHODE ISLAND™

Makena (Generic Hydroxyprogesterone)

Fax Form to: 1-866-423-0945;
Pharmacy Dept Phone 1-401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Please complete the following information: **Date of Request: ____/_____/_____**

Do you need this request decisioned within 24 hours? (72 hours is our normal turn-around-time)

PATIENT INFORMATION (complete all requested information)			
Full Name:	❑ Male ❑ Female	**Date of Birth:**	
Member ID:	**Phone Number:** ( ) -	**Allergies:**	
Address:	**City:**	**State:**	**Zip Code:**

PRESCRIBER INFORMATION (complete all requested information)			
Prescriber Full Name:		**Specialty:**	
NPI:	**Office Contact Name:**	**Office Phone:**	**Office Fax:**
Address:	**City:**	**State:**	**Zip Code:**

REQUESTED MEDICATION INFORMATION (complete all requested information)			
Medication Requested:	**Strength:**	**Quantity:**	**Duration of Therapy:**
Directions for Use:	**Diagnoses (ICD-10) Related to Requested Medication:**		

❑ **New Therapy** ❑ **Continuation of Therapy** **(If Continuing, provide start date of therapy: _____/_____/_____)**

HOW WILL MEDICATION BE PROVIDED TO MEMBER:

❑ **Filled at Pharmacy**

❑ **Provided by office/facility (Specify Facility: _____ and NPI _____)**

CLINICAL ASSESSMENT (provide all information requested below):
1. Please indicate if patient is currently pregnant with singleton.

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2. Please provide patient's history of singleton spontaneous preterm birth:

Full Name:	**Date of Birth:**	**Insurance ID#:**

CLINICAL ASSESSMENT (continued):
3. Please provide patient's current gestational weeks and when the requested medication will be initiated (i.e. gestational weeks).
Use the Space below to provide additional pertinent information:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature_____ Date_____

Completed form must be faxed to **Neighborhood at fax # 866-423-0945.**