OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Makena™ (17-hydroxyprogesterone caproate -17-OHPC) **(J1726) (Medical)**

DRUG INFORMATON: Authorization may be delayed if incomplete.

Drug Form/Strength/Quantity/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSING:

- ❑ Single and Multi dose vials: intramuscularly at a dose of 250 mg (1 mL) once weekly (every 7 days) in the upper outer quadrant of the gluteus maximus by a healthcare provider (NDC 64011-243-01 (5ML) OR (NDC 64011247-02 (1ML))
- ❑ Auto Injector: Administer subcutaneously using auto-injector at a dose of 275 mg (1.1 mL) once weekly (every 7 days) in the back of either upper arm by a healthcare provider (NDC 64011-301-03)
- ❑ Begin treatment between 16 weeks, 0 days and 20 weeks, 6 days of gestation
- ❑ Continue administration once weekly until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Member has a history of previous spontaneous birth at less than 37 weeks gestation and current pregnancy is a singleton pregnancy

- ❑ Calculate EDC/EDD: _____
- ❑ Current gestational age: _____ weeks: _____ days: _____

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by (check box below that applies):

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 3/31/2009
REVISED/UPDATED: ~~6/2/2011; 8/18/2011; 4/2/2012; 4/19/2012; 10/1/2012; 4/9/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/17/2015; 7/8/2015~~; ~~12/30/2015~~; ~~1/29/2016~~; ~~8/18/2016~~; ~~9/22/2016~~; ~~12/11/2016~~; ~~7/24/2017~~; ~~2/9/~~2018; (Reformatted) 3/17/2019; 7/7/2019; 9/24/2019; **12/01/2020**;