MAKENA
REFERRAL FORM
Fax: 270-247-6033
or 270-251-3571

DUNCAN SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066

Phone: 270-247-3725

Today's Date: Needs by Date: Ship to: ☐Patient ☐Office

Patient Information	Prescriber Information
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home & Cell #:	DEA #: State Lic#:
SSN:	NPI#:
DOB: Sex:	Phone: Fax:
Drug Allergies:	Contact Person:

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible:

Clinical Information—Statement Of Medical Necessity

Diagnostic Information & Prior Treatment History

Is the patient pregnant with a singleton? ☐ Yes ☐ No

Does patient have a history of singleton spontaneous preterm birth (<37 weeks of gestation)? ☐ Yes ☐ No

Year of previous preterm delivery _____ Gestational age at delivery _____

Current pregnancy Gestational Age: _____weeks _____days

Date recorded: _____

ICD-10 Code

☐009.212 Supervision of pregnancy with history of preterm labor, second trimester
☐009.213 Supervision of pregnancy with history of preterm labor, third trimester
☐009.219 Supervision of pregnancy with history of preterm labor, unspecified trimester
☐Other: _____

Prescription Information

✓	MEDICATION	DIRECTIONS	QTY	REFILLS
☐	Makena Auto-Injector 275 mg/1.1mL	Inject 1.1 mL SQ via auto-injector each week (every 7 days) until 37 weeks or delivery, whichever comes first	_____	_____
☐	Makena 250 mg/mL	Inject 1 mL IM each week (every 7 days) until 37 weeks or delivery, whichever comes first	_____	_____
☐	Makena 1,250 mg/5mL ☐ Dispense as Written	Inject 1 mL IM each week (every 7 days) until 37 weeks or delivery, whichever comes first	_____	_____
☐	18-g needle & 3mL syringe		_____	_____
☐	21-g, 1½" needle		_____	_____

Revised Date: 08/22/2018

Prescriber Signature: Date:

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to another pharmacy of the patient's choice or within his/her provider network