MAKENA/
HYDROXYPROGESTERONE
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** **Other:**

PATIENT INFORMATION		**PRESCRIBER INFORMATION**	
Patient Name:	DOB:	Prescriber Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Home & Cell #:		NPI#:	State Lic#:
Patient Email Address:		Phone:	
SSN:	Medicaid ID#:	Fax:	Office Contact:
Drug Allergies:		Contact Email:	

Office Preferred Method of Contact: ☐ Fax ☐ Email ☐ Phone *(Please provide direct phone #):*

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
☐	HYDROXYPROGESTERONE 250mg/mL	Inject 1mL IM each week (every 7 days) until 37 weeks or delivery, whichever comes first		
☐	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		
☐	18-g needle & 3mL syringe			
☐	21-g, 1½" needle			

Revised Date: 04/08/2020

By signing below, I certify that the above therapy is medically necessary. (Specify below if the brand name product is required)

Date Substitution Allowed Date Dispense As Written