

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



DUNCAN
 SPECIALTY PHARMACY

1522 Cuba Road
 Mayfield, KY 42066
 Phone: 270-247-3725

Today's Date:

Needs by Date:

Ship to: Patient Office Other:

PATIENT INFORMATION	
Patient Name:	DOB:
Address:	
City, State, Zip:	
Home & Cell #:	
Patient Email Address:	
SSN:	Medicaid ID#:
Drug Allergies:	

PRESCRIBER INFORMATION	
Prescriber Name:	
Address:	
City, State, Zip:	
NPI#:	State Lic#:
Phone:	
Fax:	Office Contact:
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
<input type="checkbox"/>	HYDROXYPROGESTERONE 250mg/mL	Inject 1mL IM each week (every 7 days) until 37 weeks or delivery, whichever comes first	_____	_____
<input type="checkbox"/>	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	_____	_____
<input type="checkbox"/>	18-g needle & 3mL syringe		_____	_____
<input type="checkbox"/>	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 _____

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
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