Makena®
hydroxyprogesterone
caproate injection

Makena® Prescription Form

Fax completed form directly to the pharmacists at Triangle Compounding Pharmacy at: 919-858-5145 OR 866-902-5755
Call the pharmacy about rush orders at: 919-858-0809 OR 866-858-0809

STEP 1 Complete Patient & Insurance Information

First Name | Last Name | MI

Address

City | State | ZIP

Home Phone # | Work Phone #

Cell Phone # | Best Time to Contact ☐ Morning ☐ Day ☐ Evening | Email

Date of Birth | Primary Language if Not English:

Medicaid ID#

Step 2 Read and Sign Voluntary Patient Authorizations

I. For purposes of these Authorizations:

"**AMAG**" means AMAG Pharmaceuticals, Inc., and its affiliates, subsidiaries, representatives, agents and contractors including the Makena Care Connection; "**PHI**" means personal health information, including, but not limited to, information relating to your medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription or by you directly; and "**De-Identified Data**" means information that will not be specifically identifiable to you or your baby. For example: AMAG may publish a report that says, "On Tuesday, 5 patients were contacted." You may be one of those 5 patients, but the information would not be traceable to you.

Access: Your treatment, payment, enrollment, or eligibility for benefits ("**Access**") is not conditioned on signing any Authorization. PHI can be subject to special protections by law, such as HIPAA. Unlike your healthcare provider, however, AMAG is not "covered" by HIPAA, which means that any PHI disclosed to AMAG is not controlled by HIPAA. AMAG agrees to only use your PHI as you authorize below, and to not sell your PHI to a third party.

Copy, Expiration, and Cancellation Rights: You are entitled to a copy of each Authorization. Except as to De-Identified Data, each Authorization you sign expires five (5) years from the date signed below. You may cancel any Authorization at any time by mailing a letter requesting such cancellation to AMAG c/o AllCare Plus Pharmacy, 50 Bearfoot Rd., Northborough, MA 01532, or by phone by calling 1-800-847-3418, but this cancellation will not apply to any information already used through the Authorization.

II. PHI Authorization: By signing this Authorization, I authorize my health plans, healthcare providers, and pharmacies to disclose my PHI to AMAG for the following purposes: (1) to assist with my obtaining and being treated with Makena, such as to: (a) establish my eligibility for benefits; (b) communicate with my healthcare providers and me about my medical care; (c) help third parties provide care-related products, supplies, or services; and (d) register me in any product registration program required for my treatment; (2) to contact me during and after my treatment to: (a) provide me with treatment or support materials; and (b) ask me to participate in patient programs and surveys; and (3) to review and publish De-Identified Data. Further, I understand and agree that: (i) my PHI disclosed under this Authorization is no longer protected by federal privacy laws; (ii) my pharmacy may share my PHI related to the dispensing of Makena, and that my pharmacy may be paid for that information; (iii) I may refuse to sign this Authorization and still have Access; and (iv) I understand my Copy, Expiration, and Cancellation Rights.

→ Patient or Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____

III. Adherence Support Authorization: I have provided my PHI Authorization above and wish to participate in an adherence support program ("Program") at no cost to me, designed to help me stay on track with treatment and provide me with educational information. By signing this Authorization, I acknowledge and agree that: (1) I am voluntarily choosing to enroll in this Program; (2) AMAG may use my PHI to provide the Program; (3) AMAG may contact me via phone, email, and mail to provide the Program; (4) AMAG may review and publish De-Identified Data it receives from the Program; (5) I may refuse to sign this Authorization and still have Access; and (6) I understand my Copy, Expiration, and Cancellation Rights.

IV. Agent: I hereby authorize the physician or the physician employees to accept delivery of the medication for administration acting as my agent.

→ Patient or Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Fax completed form to 919-858-0809 or 866-902-5755

STEP 3 Patient Eligibility

Is your patient pregnant with a singleton and have a history of singleton spontaneous preterm birth (<37 weeks of gestation)? Please see full prescribing information. ☐ Yes ☐ No

Current Gestational Age: _____ weeks _____ days Date recorded: _____
Is the patient currently receiving Makena? ☐ Yes ☐ No

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: _____

Note: The ICD-10 codes start with an uppercase "O" which is followed by a zero.

STEP 4 Prescriber Information

Prescriber's Name (Last, First)

Address | City | State | ZIP

Practice Name | Office Phone # | Office Fax #

NPI # | Medicaid Provider #

Office Contact(s) | Direct Phone #

After-hours Phone # | Email

Preferred Method of Communication ☐ Phone ☐ Fax ☐ Email

STEP 5 Complete Makena Rx (J1726, previously known as J1725 or Q9986)

Subcutaneous Auto-Injector

Rx: Makena (hydroxyprogesterone caproate injection) 275 mg/1.1 mL (250 mg/mL)

☐ Dispense quantity 4 x 1 single-dose, pre-filled subcutaneous auto-injectors (64011-301-03) X ___ refills until 37 weeks (ie, through 36 weeks) or delivery, whichever comes first

Sig: Inject 1.1 mL subcutaneously via auto-injector each week (every 7 days)

-OR-

Intramuscular Injection

Rx: Makena (hydroxyprogesterone caproate injection) 250 mg/mL

☐ Dispense quantity 4 x 1 mL single-dose vials (64011-247-02) X _____ refills until 37 weeks (ie, through 36⁵weeks) or delivery, whichever comes first

Sig: Inject 1 mL IM each week (every 7 days)

☐ 18-g needle & 3 mL syringe _____ # X _____ refills

☐ 21-g, 1½" needle _____ # X _____ refills

Preferred Injection Setting:

☐ Healthcare provider office

☐ Home healthcare administration by Optum® home nursing services (weekly assessment and injection), if approved by insurance

☐ Other: _____, if approved by insurance

Please Ship Makena to: ☐ Prescriber ☐ Patient **Desired Start Date:** _____

STEP 6 Read and Sign Prescriber Authorization

I authorize AMAG Pharmaceuticals, Inc., and its affiliates, agents and contractors ("AMAG") to be my designated agent to (1) provide any information on this form to the Makena Care Connection for use as authorized by the above named patient (2) provide any information on this form to the insurer of the above named patient and (3) forward the above prescription by fax or by other mode of delivery to a pharmacy that can provide the prescribed medication for the above named patient. If my patient has not signed the Patient Authorization section of this form, I certify that I have my patient's HIPAA authorization for the release of my patient's identification and insurance information to AMAG for benefits verification and coordination of benefits.

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

→ Prescriber's Signature: _____ Date: _____

→ Dispense As Written/Do Not Substitute: _____ Date: _____