UnitedHealthcare Community Plan

Makena - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Does the patient have a diagnosis of singleton pregnancy? □ Yes □ No**
  If no, list diagnosis: _____

- **Does the patient have a prior history of singleton preterm delivery before 37 weeks of gestation due to either of the following: □ Yes □ No (check which applies)**
  □ Spontaneous preterm labor □ Premature rupture of membranes

- **Will Makena be initiated on or after 16 weeks 0 days and continued until 36 weeks 6 days of gestation or delivery, whichever comes first? □ Yes □ No**
  If yes, list: _____

- **Is the requested dose within the plan's quantity limit: □ Yes □ No (check which applies)**
  (Vial: 250mg IM once weekly; Auto-Injector: 275mg SQ once weekly)
  If no, list reason: _____
  _____

- **Will the length of Makena therapy exceed 21 weeks? □ Yes □ No**
  If yes, list length of therapy: _____

- **Has the patient demonstrated failure or intolerance to a majority of the preferred alternatives for the given diagnosis? □ Yes □ No □ N/A (No preferred formulary alternatives available)**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
  If no, list reason: _____
  _____

Provider Signature: _____ **Date:** _____