Makena® Prescription Form

To ensure enrollment, please fax to the Makena Care Connection® (1-800-847-3413)
Telephone 1-800-847-3418 • www.makena.com

Makena®
hydroxyprogesterone
caproate injection

STEP 1 — Complete Patient and Insurance Information (Please Include Copies of Front and Back of Insurance Cards)

First Name _____ Last Name _____ MI _____

Address _____

City _____ State _____ ZIP _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Best Time to Contact _____ Email _____

Date of Birth _____ Primary Language if Not English: _____

Known Allergies: _____

☐ Patient does not have insurance.

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM) _____ BIN # _____

ID # _____ Group # _____ PBM Phone # _____

Primary Medical Insurance _____ Cardholder Name _____

Date of Birth _____ Policy ID # _____

Primary Insurance Phone # _____ Relationship to Cardholder _____

Note: If a patient has secondary insurance, please have her provide a copy of the insurance card (front and back).

STEP 2 — Read and Sign Patient Authorization

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Protected Health Information"), to Lumara Health — the Makena Care Connection — and its representatives, agents, and contractors (collectively "Lumara Health") for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party including, but not limited to specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to contact me with educational or treatment support materials and requests for participation in patient programs related to treatment. I understand that my Protected Health Information disclosed under this Authorization may be redisclosed by Lumara Health and is no longer protected by federal privacy laws. I am aware that my pharmacy may disclose information related to the processing and dispensing of Makena that contains Protected Health Information, and that my pharmacy may receive remuneration for that information. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Lumara Health, 2730 S. Edmonds Lane #300, Lewisville, TX 75067, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below.

X Patient or Legal Guardian Signature: _____ Relationship to Patient: _____ Date: _____

As a patient who has been prescribed Makena, I have access to *My Adherence Program* by Lumara Health ("Program"), a program designed to help me stay on track with treatment and provide me with educational information throughout my pregnancy. I understand that my participation in the Program will mean that I may be contacted via phone, email, and mail by representatives of NurseWise, a division of Centene Corporation and business partner of Lumara Health that administers the Program. By signing below, I acknowledge that I am voluntarily choosing to participate in this Program and I understand that my failure to enroll in the Program will not affect my treatment with Makena or eligibility for any benefits that I may be eligible to receive. If I decide to participate in the Program, I understand and agree that the data provided to NurseWise, which may include Protected Health Information will be specifically identifiable to me or my baby and will be used by NurseWise solely in the provision of the Program. I further understand that any data collected in the provision of those services for uses outside of the Program will be de-identified and will not be specifically identifiable to me or my baby, and may be used by NurseWise, Lumara Health or their affiliated companies and agents for their internal business purposes. I further acknowledge and give permission for these entities to publish such data in an aggregate format in a medical journal or other similar publication. I understand that I may discontinue participation in the Program or withdraw my consent to use my medical information at any time, by calling 1-844-660-0867; or writing *My Adherence Program* by Lumara Health, c/o NurseWise, 7700 Forsyth Blvd., Clayton, MO 63105.

X Patient or Legal Guardian Signature: _____ Relationship to Patient: _____ Date: _____

STEP 3 — Patient Eligibility

Does the patient meet FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)? ☐ Yes ☐ No

Current Gestational Age: _____ weeks _____ days Date recorded: _____

ICD-9 Code: ☐ v23.41 (pregnancy with a history of preterm labor)

☐ Other: _____

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: _____

Is the patient currently receiving Makena? ☐ Yes ☐ No

Is the patient currently receiving compounded HPC ("17P")? ☐ Yes ☐ No

STEP 4 — Complete and Sign Makena Rx

Prescriber's Name (Last, First) _____ NPI # _____ Office Tax ID # _____

Address _____ Medicaid Provider # _____

City _____ State _____ ZIP _____ Office Contact(s) _____ Direct Phone # _____

Practice Name _____ Office Phone # _____ Office Fax # _____ After-hours Phone # _____ Email _____

Preferred Method of Communication ☐ Phone ☐ Fax ☐ Email

Rx: Makena (hydroxyprogesterone caproate injection) 250 mg/mL (J1725)

☐ Dispense 1 x 5 mL multi-dose vial (64011-243-01) X _____ refills

Sig: Inject 1 mL IM each week

☐ 18-g needle & 3 mL syringe _____ #

☐ 21-g, 1½" needle _____ #

Preferred Injection Setting:

☐ Healthcare Provider Office

☐ Makena @Home _____, if approved by insurance

Please Ship Makena to:

☐ Prescriber

☐ Patient

Desired Start Date:

_____

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

X Prescriber's Signature: _____ Date: _____

Dispense As Written/Do Not Substitute ☐ _____

STEP 5 — Read and Sign Prescriber Authorization

I authorize Sonexus Health to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with the Makena Care Connection to the insurer of such patients and/or my patient, and to obtain any information about such patients, including any Protected Health Information (as defined in 45 CFR 160.103) from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. Sonexus Health may de-identify any and all Protected Health Information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, Sonexus Health is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any Protected Health Information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

X Prescriber's Signature: _____ Date: _____

Fax completed form and insurance cards (front and back) to: 1-800-847-3413.

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If you haven't received a call from the Makena Care Connection® within 2 business days of sending this fax, please call 1-800-847-3418.