HYDROXYPROGESTERONE CAPROATE – effective AUG 2022

****PRESCRIPTION FORM FOR HOME ADMINISTRATION****

Fax signed form to: 866-252-4293 or 866-731-9011 – OR – scan signed form to email: OBHIntake@optum.com

NOTE: COPY OF CURRENT INSURANCE CARD (FRONT AND BACK) MUST ACCOMPANY THIS SUBMISSION. Initiate and manage homecare **PER OPTUM PROTOCOLS** as provided for the following services OR physician to call Optum (800-950-3963) for other orders

PATIENT INFORMATION

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

D.O.B. _____ Due Date: _____ Ht: _____ Wt: _____ Allergies: _____

Patient Location (at time of referral): ❑ Home ❑Hospital (name):_____ Preferred Language: ❑ English ❑ Other: _____

Insurance Carrier Name, Policy #, phone #: _____

Form completed by: (Name, title): _____ Phone #: _____

HOME ADMINISTRATION OF HYDROXPROGESTERONE CAPROATE SERVICES
(check payer grid for coverage)

SERVICE REQUESTED START OF SERVICE WILL OCCUR UPON VERIFICATION, PATIENT ACCEPTS CARE, RECEIVES DISPENSED MEDICATION	BASED ON THE FOLLOWING CRITERIA *(check all that apply)*
OPTUM WILL PROVIDE MEDICATION WHERE INSURANCE ALLOWS ❑ **HOME ADMINISTRATION OF HYDROXYPROGESTERONE CAPROATE (HPC)** Dispense and administer generic Makena 250 mg (1 ml) IM weekly.	❑ History of spontaneous preterm birth of singleton less than 37 weeks' gestation. Now pregnant with one baby. ❑ Gest age of previous PTD _____. ❑ Patient needs home administration related to compliance risk, transportation, work scheduling, or childcare issues. ❑ Office does not provide injections. ❑ Other: _____

INITIAL PRESCRIBER (*Signature Required*)

Practice Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ ZipCode: _____

Phone/Extension: _____ Fax: _____ Email: _____

IF ONGOING CARE OF THIS PATIENT WILL BE MANAGED BY ANOTHER PROVIDER, COMPLETE THE INFORMATION BELOW. **As the prescriber, you are responsible for full care of this patient unless/until the ongoing managing provider's prescription is received by Optum.** At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued.

Provider's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZipCode: _____

I certify that this patient is under my care and that the above services are medically necessary and are authorized by me with the above written plan of treatment. My signature acknowledges that (i) I have received and reviewed the protocol that accompanies this plan of treatment and understand and accept responsibility for the patient's care, and (ii) my state medical license is current and valid as indicated below. Start of service will occur upon completion of benefits and eligibility, verification, receipt of medication from dispensing pharmacy and patient agreement to start of service date.

Prescriber Signature: _____ (Print Name): _____ Date: _____

NPI#: _____ License # _____ State _____

For Internal Use Only:

Telephone Order From: _____

❑ RBV By (Optum Nurse): _____, RN Date: _____ Time: _____

❑ Prescription reviewed by Optum RN: _____ Date: _____

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