Duncan Specialty Pharmacy

Fax: 270-247-6033 or 270-251-3571
Phone: 270-247-3725

DUNCAN SPECIALTY PHARMACY

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:

Social Security Number | Known Allergies

☐ Patient does not have insurance

Prescription Drug Insurer/Pharmacy Benefit Manager (PMB) | BIN #

ID # | Group # | PMB Phone #

Primary Medical Insurance | Cardholder Name

Date of Birth | Policy ID #

Primary Insurance Phone # | Relationship to Cardholder

Secondary Medical Insurance | Cardholder Name

Date of Birth | Policy ID #

Secondary Insurance Phone # | Relationship to Cardholder

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 Ther-Rx Corporation — the Makena Care Connection — and its representatives, agents, and contractors (collectively "Ther-Rx") 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 branded support materials related to my treatment. I understand that my Protected Health Information disclosed under this authorization may be redisclosed by Ther-Rx 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 Ther-Rx Corporation, 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: _____

STEP 3 — Patient Eligibility

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

Previous Preterm delivery of singleton at: 1)_____weeks 2)_____weeks

Current Gestational Age:_____weeks____days Date recorded_____

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

Is the patient currently on compounded HPC ("17P")? ☐ YES ☐ NO

STEP 4 — Complete and Sign Makena Rx

Prescriber's Name (Last, First)

Address

City | State | Zip

Practice Name | Office Phone | Office Fax #

NPI # | Office Tax ID #

Medicaid Provider #

Office Contact(s) | Direct Phone #

After-hours Phone # | Email

Preferred method of communication? ☐ Phone ☐ Fax ☐ Email

Rx: Makena (hydroxyprogesterone caproate injection) 250 mg/mL, 5 mL multidose vial

☐ Dispense 1 vial, followed by_____ refills for a complete course of therapy
Sig: Inject 1 mL IM each week

☐ 18-g needle & 3 mL syringe_____ #

☐ 21-g, 1 ½ " needle_____#

Preferred Injection Setting:

☐ Healthcare Provider Office

☐ Makena @Home by Walgreens Infusion Services, if approved by insurance

Please Ship Makena to:

☐ Prescriber

☐ Patient

Desired Start Date: _____

I certify that this therapy is medically necessary 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

By signing this form & utilizing our services, you are authorizing Duncan Prescription Center & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies.

Prescriber Signature: _____ Date: _____