Makena Enrollment Form

Please fax the completed form to:

601-420-4040

Signature Care Program

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:
Emergency Contact:	Facility Name:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

Please Fax a copy of clinic notes/labs to expedite the PA process

CLINICAL INFORMATION	
Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Allergies:	Medications on:
Height: feet inches	Weight: lbs.
Is this a singleton pregnancy? ☐ Yes ☐ No	If not, please indicate status: ☐ Twins ☐ Triplets ☐ Other:
Does the patient have a prior history of spontaneous premature birth before 37 weeks' gestation? ☐ Yes ☐ No	
Number of weeks gestation today?	If not starting 17P today, number of weeks gestation at proposed treatment initation?
Other notes:	

PRESCRIPTION INFORMATION

Medication:	**Dosage/Strength:**	**Directions:**	**Quantity:**	**Refills:**
Makena®	☐ 250mg 4x1 mL vial ☐ 275mg 4x1 Autoinject Pen	☐ Healthcare professional to inject 250mg IM weekly ☐ Healthcare professional to inject 275mg SC weekly	4 mL 4.4mL	

Office Contact Name: _____ Preferred phone number & extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form to 601-420-4040