

Makena Enrollment Form

Please fax the completed form to:

601-420-4040



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:	<input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:	Medications on:
Height: feet inches	Weight: lbs.
Is this a singleton pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, please indicate status: <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other:
Does the patient have a prior history of spontaneous premature birth before 37 weeks' gestation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of weeks gestation today?	If not starting 17P today, number of weeks gestation at proposed treatment initiation?
Other notes:	

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Makena®	<input type="checkbox"/> 250mg 4x1 mL vial <input type="checkbox"/> 275mg 4x1 Autoinject Pen	<input type="checkbox"/> Healthcare professional to inject 250mg IM weekly <input type="checkbox"/> 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

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