HYDROXYPROGESTERONE PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
G/P:	**EDC:**
Current Gestational Age: _____ week(s) _____ day(s)	**Date Recorded:**

Is this the patient's first dose? ☐ Yes ☐ No – next dose due: _____

Hydroxyprogesterone Prescription

☐ **Hydroxyprogesterone caproate 250 mg/mL x _____ doses.**
Nurse to administer hydroxyprogesterone caproate 250 mg/mL IM weekly.
Include an 18-gauge needle, 3 mL syringe, and 21-gauge 1 ½" needle with each dose.

☐ **Makena® Auto-Injector 275 mg (in 1.1 mL) x _____ doses.**
Nurse to administer Makena® Auto-Injector 275 mg (in 1.1 mL) subcutaneously weekly.

Do not start injections prior to 16 weeks gestation.
Injections to be given every 5 to 9 days (goal of every 7 days) until 36 weeks and 6 days or _____.
If patient will be seen in provider's office (i.e. dispense the medication only to provider's office) – check here: ☐

Ancillary Orders

Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

