

# HYDROXYPROGESTERONE PRESCRIBER ORDER FORM

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



<b>Patient Name:</b>	<b>Date of Birth:</b>			
<b>Address:</b>				
<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

## Clinical Information

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

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

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

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