BLUEGRASS PHARMACY | MAKENA® PRESCRIPTION FORM

BLUEGRASS Pharmacy
A Member of the wellpartner Family

TO ENSURE ENROLLMENT, FAX TO THE MAKENA CARE CONNECTION®: 1.800.847.3413 | **PHONE:** 1.800.847.3418 | www.makena.com

1. COMPLETE PATIENT AND INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

First Name: Last Name: MI:

Address:

City, State, ZIP:

Cell Phone: - - Home Phone: - -

Work Phone: - - Email:

DOB: / / Primary Language if not English:

Known allergies

:

Prescription Drug Insurer/Pharmacy Benefit Manager (PBM):

ID #: Group #: BIN #: PBM Phone #: - -

Primary Medical Insurance: Policy ID #:

Primary Cardholder Name: DOB: / /

Relationship to Cardholder:

Secondary Medical Insurance: Policy ID #:

Secondary Cardholder Name: DOB: / /

Relationship to Cardholder:

◯ Patient does not have insurance

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 Lumara Health – the Makena Care Connection – and its representatives, agents, and contractors (collectively, "Lumara Health") 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) register me in any applicable product registration program required for my treatment; and (5) to contact me with educational or treatment support materials and requests for participation in patient programs related to treatment. I understand that my Protected Health Information disclosed under this Authorization may be redisclosed by Lumara health 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 Lumara Health, 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 (5) years form the date signed below.

X _____ _____ / /

PATIENT OR LEGAL GUARDIAN SIGNATURE: RELATIONSHIP TO PATIENT DATE

3. PATIENT ELIGIBILITY

Does the patient meed FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)? ◯ Yes ◯ No Current Gestational Age: _____ weeks _____ days Date recorded: / /

ICD-9C ◯ v23.41 (pregnancy with a history of preterm labor) ◯ Other:

Is the patient currently receiving Makena? ◯ Yes ◯ No Is the patient currently receiving compounded HPC ("17P")? ◯ Yes ◯ No

4. COMPLETE AND SIGN MAKENA RX

Prescriber's Name (please print): NPI #: DEA #: Office Contact(s)

Address City State ZIP

Office Phone #: - - Office Fax #: - - After-hours Phone #: - - Email:

Preferred method of communication: ◯ Phone ◯ Fax ◯ Email

Rx: Makena (hydroxyprogesterone caproate injection) 250mg/ml, 5mL multidose vial (J1725)

◯ Dispense 1 vial, followed by _____ refills for a complete course of therapy - Sig: Inject 1 mL IM each week

◯ 18g needle & 3 mL syringe _____ # ◯ 21g, 1 1/2" needle _____ #

Preferred injection setting: ◯ Healthcare Provider Office ◯ Makena @home by Walgreens Infusion Services, if approved

Please ship Makena to: ◯ Prescriber ◯ Patient Desired Start Date: / /

I certify that this therapy is medically necessary and this information is accurate to the best of my knowledge.

X _____ / /

PRESCRIBER'S SIGNATURE: DATE

◯ Dispense As Written/Do Not Substitute:

5. READ AND SIGN PRESCRIBER AUTHORIZATION

I authorize Sonexus Health to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with the Makena Care Connection to the insurer of such patients and/or my patient, and to obtain any information about such patients, including any Protected Health Information (as defined in 45 CFR 160.103) from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. Sonexus Health may de-identify any and all Protected Health Information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, Sonexus Health is required to comply with, and by its signature hereto, agrees that it will comply with the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any Protected Health Information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

X _____ / /

PRESCRIBER'S SIGNATURE: DATE

Fax completed form and insurance card(s) (front and back) to: 1.800.847.3413