

CRITERIA FOR PRIOR AUTHORIZATION

Makena® (hydroxyprogesterone caproate)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Hydroxyprogesterone Caproate (Makena®)

CRITERIA FOR INITIAL PRIOR AUTHORIZATION FOR HYDROXYPROGESTERONE CAPROATE: (must meet all of the following)

- Patient must have a singleton pregnancy
- Patient must have a history of singleton spontaneous preterm birth.
- Patient must be 16 years of age or older.
- Treatment must begin between 16 weeks, 0 days and 20 weeks, 6 days of gestation.
- Treatment must stop at week 37 (through 36 weeks, 6 days) gestation or delivery, whichever occurs first.

LENGTH OF APPROVAL: Up to 20 weeks

Limit one (1) mL every (1) week with a total quantity limit of twenty (20) mL per pregnancy

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE