ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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SPASSIST®
MAKENA®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Always to Physician's Office □Alternate Site:(enter below)
Clinical Name:_____ Contact Name:_____
Address:_____ Phone:_____ Fax:_____
Suite:_____ City:_____ State:_____ Zip:_____

Patient Eligibility:
Is your patient pregnant with a singleton and have a history of singleton spontaneous preterm birth (<37 weeks of gestation)? □Yes □No
Current Gestational Age: _____weeks _____days Date recorded: _____ Is the patient currently receiving Makena? □Yes □No

ICD-10 Code:
□ O09.212 Supervision of pregnancy with history of preterm labor, second trimester
□ O09.213 Supervision of pregnancy with history of preterm labor, third trimester
□ O09.219 Supervision of pregnancy with history of preterm labor, unspecified trimester
□ Other: _____

Note: The ICD-10 codes start with an uppercase "O" which is followed by a zero.

Drug Name	Strength	Directions	Quantity	Refills
□Makena® Vial (Hydroxyprogesterone Caproate)	□250mg/mL	□Inject 1mL (250mg) intramuscularly every 7 days □Other:_____ □ Supplies: 18g needle, 3mL syringe, 21mg needle	□ (#4) 1mL vial □ (#1) 5mL vial □ Other_____	
□Makena® Autoinjector	□275mg/1.1mL	□Inject 1.1mL (275mg) subcutaneously every 7 days □Other:_____	□ (#4) auto-injectors	
□Other				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:_____
□Please select if you would like the patient enrolled in a Manufacturer's Assistance Program