DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD PROPOSED CRITERIA

Makena™ (hydroxyprogesterone caproate) Injection

Makena™ is a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:

   Authorization will be given if all of the following criteria are met and documented:

   a. Treatment with Makena™ is ordered by or recommended by a physician specializing in Obstetrics/Gynecology, Perinatology or Maternal/Fetal Medicine; AND

   b. The recipient is female, 16 years of age or older, and pregnant with a singleton pregnancy; AND

   c. The recipient is between 16 weeks 0 days and 20 weeks 6 days of gestation when therapy begins AND

   d. The recipient has a history of singleton spontaneous preterm birth (prior to 37 weeks gestation); AND

   e. The recipient does not have other risk factors for preterm birth; AND

   f. There is no known major fetal anomaly or fetal demise; AND

   g. The recipient has not been treated with heparin therapy during the current pregnancy; AND

   h. The recipient has no history of thromboembolic disease; AND

   i. The recipient has no maternal/obstetrical complication (e.g., current or planned cerclage, hypertension requiring medication or seizure disorder)

2. Quantity Limitations:

   Quantity limit: 1 vial per rolling 30 days (5 doses)

3. Length of Approval: Makena will be approved for use until the recipient is 36 weeks 6 days of gestation or delivery, whichever occurs first.