Orilissa (Elagolix) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #:_____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Orilissa	_____	_____	Specify: _____

7. Diagnosis:_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for elagolix containing drugs Payment will be considered for patients when the following is met:

1) Pregnancy has been ruled out; and
2) Patient does not have osteoporosis; and
3) Patient does not have severe hepatic impairment; and
4) Patient is not taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil); and
5) Requests for elagolix (Orilissa) will be considered under the following conditions:
   a) Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
   b) Patient has documentation of a previous trial and therapy failure with at least one preferred oral
   c) NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken
   d) concurrently; and
   e) Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
   f) Initial requests will be considered for 3 months. Additional requests will be considered upon
   g) documentation of improvement of symptoms.
   h) Requests will be considered for a maximum of 24 months for the 150mg dose and 6 months for the
   i) 200mg dose; or

1) Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) will be considered under the following conditions:
   a) Patient is premenopausal; and
   b) Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and
   c) Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and
   d) Patient has documentation of a previous trial and therapy failure with tranexamic acid.
   e) Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement in symptoms.
   f) Requests will be considered for a maximum of 24 months of treatment

Non-preferred
☐ Oriahnn ☐ Orilissa

Initial requests:
☐ Yes ☐ No Has pregnancy been ruled out? Date of pregnancy test:_____
☐ Yes ☐ No Does patient have osteoporosis?
☐ Yes ☐ No Does patient have severe hepatic impairment?
☐ Yes ☐ No Is patient taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil)?

☐ Orilissa
Treatment failures:
Preferred oral NSAID trial:
Name/dose: _____Trial dates: _____
Failure reason/medical contraindication:_____
_____

Preferred continuous hormonal contraceptive trial:
Name/dose: _____Trial dates: _____
Failure reason/medical contraindication:_____
_____

Preferred GnRH agonist trial:
Name/dose: _____Trial dates: _____
Failure reason/medical contraindication:_____
_____

☐ Oriahnn
Is patient premenopausal? ☐ Yes ☐ No

Treatment Failures:
Preferred Continuous Hormonal Contraceptive Trial:
Name/dose: _____Trial dates: _____
Failure reason/medical contraindication:_____
_____

Tranexamic Acid Trial:
Name/dose: _____Trial dates: _____
Failure reason/medical contraindication:_____
_____

Renewal requests (Orilissa and Oriahnn):
Provide documentation of improvement in symptoms:_____
_____
_____
Treatment start date: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*