Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Orilissa® (elagolix)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Orilissa 150mg tablet ☐ Orilissa 200mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Orilissa 150mg is $30.17 per tablet. The annual cost of treatment with this drug will vary depending on the patient's circumstances.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of moderate to severe pain associated with endometriosis
2. Trial of NSAID (nonsteroidal anti-inflammatory drug) and oral contraceptive for at least 3 months each
3. Patient does not have a history of osteoporosis, does not have severe hepatic impairment, and is not pregnant

For continuation, patient must have met the following requirements:

1. The patient has experienced a clinically significant reduction in pain.
2. The provider is monitoring for decreased bone density and increased lipids.
3. The patient is compliant in taking the medication as scheduled
4. The patient tolerated the medication
5. The patient did not experience any severe adverse reactions while taking the medication

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Moderate to severe pain associated with endometriosis
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Has the member had a trial of an NSAID for at least 3 months?

☐ **Yes (please describe below)**
☐ **No**

Drug	Dose	Dates Used	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Not all requirements are met – Below is rationale for use:

_____

C. Has the member had a trial of an oral contraceptive for at least 3 months?

☐ **Yes (please describe below)**
☐ **No**

Drug	Dose	Dates Used	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Not all requirements are met – Below is rationale for use:

_____

D. Does the patient presently have any of the following conditions?:

☐ Osteoporosis
☐ Severe hepatic impairment (Child-Pugh Class D)
☐ Pregnancy
☐ None

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Last reviewed 09/2018

PriorityHealth

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Moderate to severe pain associated with endometriosis
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient experienced a clinically significant reduction in pain?

- ☐ Yes
- ☐ No, *Rationale for use:* _____

C. Is the patient being monitored for decreased bone density and increased lipids?

- ☐ Yes
- ☐ No, *Rationale for use:* _____

D. Select which of the following apply (all must be met for continuation of therapy):

- ☐ The patient is compliant in taking the medication as scheduled
- ☐ The patient tolerated the medication
- ☐ The patient did not experience any severe adverse reactions while taking the medication

Additional information

Note: Initial approval of Orilissa is limited to 6 months.

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Last reviewed 09/2018