Request for Prior Authorization
Elagolix (Orilissa)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for gonadotropin-releasing hormone (GnRH) antagonists. Payment will be considered for patients when the following is met:

1) Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
2) Pregnancy has been ruled out; and
3) Patient does not have osteoporosis; and
4) Patient does not have severe hepatic impairment; and
5) Patient is not taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil); and
6) Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and
7) Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
8) Requests will be considered for a maximum of 24 months for the 150mg dose and 6 months for the 200mg dose.

Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Orilissa

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
________	____________________	________	________

Diagnosis:____

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☐ **Initial Requests:**

Has pregnancy been ruled out? ☐ Yes ☐ No Date of pregnancy test:____________________

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)? ☐ Yes ☐ No

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:____

____

☐ **Renewal Requests:**

Provide documentation of improvement in symptoms:________________________________

____

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Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*