AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Orilissa® (elagolix)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity Limits:

- 150 mg: Maximum of 1 tablet daily; maximum treatment duration of 24 months
- 200 mg: Maximum of 2 tablets daily; maximum treatment duration of 6 months

Total collective approval duration not to exceed 24 months for all GnRH antagonist products

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Requested Dose: 150 mg, 1 tablet per day**

Initial Authorization: 6 months

❑ Member is premenopausal

❑ Member is 18 years of age or older

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- ❑ Medication is being prescribed by or in consultation with a specialist in gynecology or reproductive health
- ❑ Member has a diagnosis of moderate to severe pain associated with endometriosis
- ❑ Diagnosis of endometriosis has been confirmed by direct visualization during surgery and/or histology
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, severe hepatic impairment/disease, or concomitant use of hormonal contraceptives
- ❑ Member has history of inadequate response to the following therapies, tried for at least three (3) months each **(must submit chart note documentation of all therapy failures)**:
  - ❑ NSAIDs (non-steroidal anti-inflammatory drugs)
  - ❑ Combination (estrogen/progesterone) oral contraceptive
  - ❑ Progestins

OR

  - ❑ Member has had surgical ablation to prevent recurrence

Reauthorization: 18 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Requested Dose: 150 mg, 1 tablet per day**

Note: Therapy will NOT exceed 24 months per lifetime

- ❑ Member has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and non-menstrual pelvic pain)
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, severe hepatic impairment/disease, or concomitant use of hormonal contraceptives
- ❑ Treatment duration of Orilissa® has not exceeded a total of 24 months.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Requested Dose: 200 mg, 2 tablets per day**

Authorization Criteria: Therapy will NOT exceed 6 months per lifetime

- ❑ Member is premenopausal
- ❑ Member is 18 years of age or older
- ❑ Medication is being prescribed by or in consultation with a specialist in gynecology or reproductive health
- ❑ Member has a diagnosis of moderate to severe pain associated with endometriosis and coexisting condition of dyspareunia

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- ❑ Diagnosis of endometriosis has been confirmed by direct visualization during surgery and/or histology
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, severe hepatic impairment/disease, or concomitant use of hormonal contraceptives
- ❑ Member has history of inadequate response to the following therapies, tried for at least three (3) months each **(must submit chart note documentation of all therapy failures)**:
  - ❑ NSAIDs (non-steroidal anti-inflammatory drugs)
  - ❑ Combination (estrogen/progesterone) oral contraceptive
  - ❑ Progestins

OR

  - ❑ Member has had surgical ablation to prevent recurrence

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

__Previous therapies will be verified through pharmacy paid claims or submitted chart notes.__