TRICARE Prior Authorization Request Form for
elagolix/estradiol/norethindrone **(Oriahnn)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 24 months (lifetime expiration)

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient a premenopausal woman with diagnosed heavy menstrual bleeding associated with uterine leiomyomas (fibroids)? **Note: Non-FDA-approved uses are not approved including pain associated with endometriosis.**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had inadequate relief after at least three months of first-line therapy with a hormonal contraceptive or Intrauterine Device (IUD)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a reproductive endocrinologist or obstetrics/gynecology specialist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**

6. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have current or history of thrombotic or thromboembolic disorders or an increased risk for these events?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient a smoker over the age of 35?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the provider agree to discontinue treatment if a thrombotic, cardiovascular, or cerebrovascular event occurs or if the patient has a sudden unexplained partial or complete loss of vision, proptosis (abnormal protrusion of the eye), diplopia (double vision), papilledema (optic disc swelling), or retinal vascular lesions?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the provider agree to monitor blood pressure and discontinue treatment if blood pressure rises significantly?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have osteoporosis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Does the provider agree to advise the patient to seek medical attention for suicidal ideation, suicidal behavior, new onset or worsening depression, anxiety, or other mood changes?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have a history of breast cancer or other hormonally-sensitive malignancies?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Does the patient have known liver impairment or disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**

17. Does the provider agree to counsel patients on the signs and symptoms of liver injury?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Does the patient have undiagnosed abnormal uterine bleeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the cumulative treatment with the requested medication exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. Is the patient using the requested medication concomitantly with cyclosporine or gemfibrozil or other organic anion transporting polypeptide [(OATP)1B1] inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[5 April 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: