Prior Authorization Request Form for

elagolix (Orilissa)

USFHP Pharmacy Prior Authorization Form

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

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

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 endometriosis?	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had inadequate relief after at least three months of therapy with nonsteroidal anti-inflammatory (NSAIDs) agents or are NSAIDs contraindicated?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient had inadequate relief after at least three months of hormonal contraceptives or are hormonal contraceptives contraindicated?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication being prescribed by a reproductive endocrinologist or obstetrics/gynecology specialist?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Has the patient agreed to use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have severe hepatic impairment (Child-Pugh Class C)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Does the patient have osteoporosis?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. Will the patient be taking calcium supplementation concomitantly with Orilissa?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will Orilissa be used concomitantly with cyclosporine or gemfibrozil?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **13**
13. Will the cumulative treatment with Orilissa exceed 24 months during the patient's lifetime?	☐ 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

[05 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: