

# Prior Authorization Request Form for elagolix/estradiol/norethindrone (OriaHnn)



**JOHNS HOPKINS**  
M E D I C I N E

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HEALTHCARE

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**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: _____ Address: _____  Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____  Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete the clinical assessment:

1. Will the cumulative treatment with OriaHnn exceed 24 months during the patient's lifetime?	<input type="checkbox"/> Yes  <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 2
2. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No  <b>STOP</b> Coverage not approved
3. 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.	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No  <b>STOP</b> Coverage not approved
4. Has the patient had inadequate relief after at least three months of first-line therapy with a hormonal contraceptive or Intrauterine Device (IUD)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No  <b>STOP</b> Coverage not approved
5. Is the requested medication prescribed by a reproductive endocrinologist or obstetrics/gynecology specialist?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No  <b>STOP</b> Coverage not approved
6. Is the patient pregnant?	<input type="checkbox"/> Yes  <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 7

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<p>7. Has it been confirmed that the patient is not pregnant by (-) HCG?</p>	<p><input type="checkbox"/> Yes Proceed to question 8</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>8. Will the patient use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment?</p>	<p><input type="checkbox"/> Yes Proceed to question 9</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>9. Does the patient have current or history of thrombotic or thromboembolic disorders or an increased risk for these events?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 10</p>
<p>10. Is the patient a smoker over the age of 35?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 11</p>
<p>11. 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?</p>	<p><input type="checkbox"/> Yes Proceed to question 12</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>12. Does the patient have uncontrolled hypertension?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 13</p>
<p>13. Does the provider agree to monitor blood pressure and discontinue treatment if blood pressure rises significantly?</p>	<p><input type="checkbox"/> Yes Proceed to question 14</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>14. Does the patient have osteoporosis?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 15</p>
<p>15. Does the provider agree to assess baseline and periodic bone mineral density?</p>	<p><input type="checkbox"/> Yes Proceed to question 16</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>16. 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?</p>	<p><input type="checkbox"/> Yes Proceed to question 17</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>17. Does the patient have a history of breast cancer or other hormonally-sensitive malignancies?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question 18</p>

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18. Does the patient have known liver impairment or disease?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>19</b>
19. Does the provider agree to counsel patients on the signs and symptoms of liver injury?	<input type="checkbox"/> Yes Proceed to question <b>20</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
20. Does the patient have undiagnosed abnormal uterine bleeding?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question <b>21</b>
21. Is the patient using Oriahnn concomitantly with cyclosporine or gemfibrozil or other organic anion transporting polypeptide [(OATP)1B1] inhibitors?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> 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

[11 November 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: