Prior Authorization Request Form for

elagolix (Orilissa)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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? Pregnancy test required before initiating treatment.	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Has the patient agreed to use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Does the patient have severe hepatic impairment (Child-Pugh Class C)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**
9. Does the patient have osteoporosis?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Will the patient be taking calcium supplementation concomitantly with Orilissa?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will Orilissa be used concomitantly with cyclosporine or gemfibrozil?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **12**
12. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Orilissa*	☐ Yes (subject to verification) proceed to question **13**	☐ No **Sign and date below**
13. Does the patient have moderate hepatic impairment (Child-Pugh Class B)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **14**
14. Will the patient be using Orilissa at a dosage of 150 mg daily?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. How many months of therapy has the patient completed?	☐ 0 up to 9 months of therapy – **Sign and date below** ☐ Other - proceed to question **16**	
16. How many months of therapy has this patient received? Note: the maximum duration of treatment of low dose (150 mg) should not exceed 24 months; maximum duration of treatment of higher dose (200 mg) should not exceed 6 months.	_____ **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

[31 July 2019]

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