OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information is not complete, correct, or legible, the authorization can be delayed.**

Drug Requested: **Orilissa®** (lusutrombopag)

DRUG INFORMATION: Complete information below or authorization will be delayed

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

Initial Authorization Approval – 6 months

1. The member has a confirmed diagnosis of endometriosis. ❑ Yes ❑ No

AND

2. Is the member 18 years old or older? ❑ Yes ❑ No

AND

3. The member has failed an adequate trial of the following therapies: ❑ Yes ❑ No
   - non-steroidal anti-inflammatory drugs (NSAIDs),

   AND

   - hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device),

   AND

   - gonadotropin-releasing hormone (GnRH) agonist (e.g., nafarelin [Synarel®], leuprolide [Lupron®], goserelin [Zoladex®])

   AND

4. Elagolix is prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist ❑ Yes ❑ No

AND

5. Pregnancy is excluded prior to initiating treatment. ❑ Yes ❑ No

AND

(continued on next page)

6. The member will use effective non-hormonal contraception during treatment with elagolix and 1 week after stopping therapy. ❑ Yes ❑ No

AND

7. The member does not have osteoporosis as evident by a Z score > -1.5 at spine and femur (total hip). ❑ Yes ❑ No

AND

8. The member does not have severe hepatic impairment (Child-Pugh C). ❑ Yes ❑ No

AND

9. The member is not on concomitant strong organic anion transport polypeptide (OATP) 181 inhibitor (e.g., cyclosporine, gemfibrozil). ❑ Yes ❑ No

Renewal Authorization Approval – 18 months. To receive approval for the 150mg tablet for a maximum duration of 24 months, the following questions must be checked. No Renewal for the 200mg tablet.

10. The member continues to meet the initial criteria. ❑ Yes ❑ No

AND

11. The member is considered to have clinically meaningful response to treatment. ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy – PropriumRx

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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 2/25/2019**