OPTIMA HEALTH PLAN

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. **Incomplete form will delay authorization process**.

Drug Requested: Orilissa™ (elagolix)

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code**: _____

Orilissa™ comes in 150 mg and 200 mg

CLINICAL CRITERIA: Check boxes below to qualify. If **not** checked, authorization will be delayed.

- **For 150 mg:**

Initial Approval Criteria - Initial Authorization is for 6 months, 1 tablet/day.
The following criteria **MUST** be met for approval of requested drug.

- ❑ Diagnosis of moderate to severe pain associated with endometriosis

AND

- ❑ **ONE** of the following:
  - ❑ History of inadequate pain control response following a trial of at least 6 months, or history or intolerance or contraindication to one of the following:
    - ❑ Danazol
    - ❑ Combination (estrogen/progesterone) oral contraceptive
    - ❑ Progestins

OR

  - ❑ Patient has had surgical ablation to prevent recurrence

Reauthorization Criteria -Reauthorization will be for 18 months, 1 tablet/day. Therapy will NOT exceed 24 months per lifetime.

- ❑ Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and non-menstrual pelvic pain)

AND

- ❑ Patient does not have coexisting moderate hepatitis impairment (maximum length of therapy is 6 months per lifetime)

AND

- ❑ Treatment duration of Orilissa™ has not exceeded a total of 24 months.

(continued on next page)

- **For 200 mg:**

Initial Criteria - Initial Authorization is for 6 months, 2 tablets/day. Therapy will NOT exceed 6 months per lifetime. The following criteria **MUST** be met for approval of requested drug.

- ❑ Diagnosis of moderate to severe pain associated with endometriosis

AND

- ❑ Coexisting condition of dysparenunia

AND

- ❑ **ONE** of the following:
  - ❑ History of inadequate pain control response following a trial of at least 6 months, or history or intolerance or contraindication to one of the following:
    - ❑ Danazol
    - ❑ Combination (estrogen/progesterone) oral contraceptive
    - ❑ Progestins

OR

  - ❑ Patient has had surgical ablation to prevent recurrence

Medication being provided by (check applicable box below):

❑ **Physician's Office** **OR** ❑ **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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 10/17/2018
REVISED/UPDATED: 12/30/2018