Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Orilissa® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe pain associated with endometriosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Orilissa <u>150mg</u>:

Select if the patient has a history of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to the following:

- ❑ Combination (estrogen/progesterone) oral contraceptive
- ❑ Danazol
- ❑ Progestins

Has the patient had surgical ablation to prevent recurrence? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following:

Does the patient have improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and non-menstrual pelvic pain)? ❑ **Yes** ❑ **No**

Does the patient have coexisting moderate hepatitis impairment? ❑ **Yes** ❑ **No**

Has the treatment duration of Orilissa exceeded a total of 24 months? ❑ **Yes** ❑ **No**

Orilissa <u>200mg</u>:

Does the patient have coexisting condition of dyspareunia? ❑ **Yes** ❑ **No**

Select if the patient has a history of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to the following:

- ❑ Combination (estrogen/progesterone) oral contraceptive
- ❑ Danazol
- ❑ Progestins

Has the patient had surgical ablation to prevent recurrence? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

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Orilissa® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.