UTERINE DISORDERS PRIOR AUTHORIZATION REQUEST FORM



OptumRx
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Phone: (800) 310-6826 Fax: (866) 940-7328



Community Plan

Today's Date			
Note: This form must be complete	ed by the p	rescribing pro	ovider.
** A II a a ations	· must be a	ompleted or t	ha waguaat will be watuwaad**
Patient's Patient	s must be c		he request will be returned**
Medicaid #		Date of	of Birth
Patient's Name		Presc	riber's Name
Prescriber's IN License #		Speci	alty
Prescriber's NPI #		Presc	riber's Signature
Return Fax #			n Phone #
Check box if requesting retro-active Pa	Α		s) of service requested for active eligibility (if applicable):
Note: Submit PA requests for retroactive	claims (dates	of service prior	to eligibility determination, but within established ubmission separately from current PA requests (dates of
service 30 calendar days or less and goil		ieridai days oi s	ubmission separately from current PA requests (dates of
	04 41	0 111	
Requested Medication	Strength	Quantity	Dosage Regimen
PA requirements for MYFEM	BREE (re	lugolix/estr	adiol/norethindrone acetate):
1. Member is 18 years of age or olde	r □ Vec □	∃ No.	
1. Member is 10 years of age of olde	1 🗀 165 🗀		
2. Select one of the following diagnos			
-		•	broids) in premenopausal females
☐ Moderate to severe pain	associated (with endometri	osis in premenopausal females
3. Negative pregnancy test in the pas	st 30 days*	□ Yes □ No	
4. Laboratam staata aanfirmaina na bar	atia diagga	s in the neet OC	Ndove* 🗆 Voc. 🗆 No.
4. Laboratory tests confirming no hep	auc disease	e in the past 30	days" Yes No
 Current diagnosis of, risk fac 		-	aindications to therapy: ☐ Yes ☐ No v of thromboembolic disorders or vascular
eventsCurrent diagnosis or history	of breast car	ncer or other h	ormone-sensitive malignancies OR increased
risk factors for hormone-sens			•
	silive malign	ancics	
Diagnosis of osteoporosisUndiagnosed abnormal uteri	J	aricies	

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Prescriber Signature:	_
6. Requested dose is 1 tablet (40/1/0.5 mg) per day $\ \square$ Yes $\ \square$ No	
If no , please explain	
 7. Previous trial and failure of one of the following: Oriahnn (elagolix/estradiol/norethindrone acetate) for menorrhagia associated with uterine le indication ONLY ☐ Yes ☐ No Orilissa (elagolix) for endometriosis indication ONLY ☐ Yes ☐ No 	eiomyomas
If no , please provide medical justification:	
8. Member will not be exceeding 24 months of therapy per lifetime with Myfembree (relugolix/estradiol/norethindrone acetate) \square Yes \square No	
If yes , provide medical justification for continued use beyond 24 months and date range or number of member has received therapy thus far:	of months
	· · · · · · · · · · · · · · · · · · ·
*Note: Chart documentation will need to be provided for questions indicated with asterisk	
PA requirements for ORIAHNN (elagolix/estradiol/norethindrone acetate):	
1. Member is 18 years of age or older \square Yes \square No	
2. Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal female: \Box Yes \Box No	s
3. Negative pregnancy test in the past 30 days* \square Yes \square No	
4. Laboratory tests confirming no hepatic disease in the past 30 days* \square Yes \square No	
 5. Provider attests that member has none of the following contraindications to therapy: Yes N Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibite Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vasce events 	wn or rozil)
 Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibite). Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vasce events. Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR in risk factors for hormone-sensitive malignancies. 	wn or rozil) cular
 Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibile). Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vasce events. Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR in 	wn or rozil) cular
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6. Requested dose is 2 capsules (1 x 300/1/0.5 mg; 1 x 300 mg) per day ☐ Yes ☐ No
If no , please explain
7. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) Yes No
If no , please provide medical justification:
8. Member will not be exceeding 24 months of therapy per lifetime with elagolix/estradiol/norethindrone acetate therapy \square Yes \square No
If yes , provide medical justification for continued use beyond 24 months and date range or number of months member has received therapy thus far:
*Note: Chart documentation will need to be provided for questions indicated with asterisk
PA requirements for ORILISSA (elagolix):
1. Member is 18 years of age or older ☐ Yes ☐ No
2. Select one of the following diagnoses: Moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia AND dose does not exceed 400 mg daily (6-month approval maximum) Moderate to severe pain associated with endometriosis AND requested dose does not exceed 150 mg daily (1 year approval)
3. Negative pregnancy test in the past 30 days* ☐ Yes ☐ No
 4. Laboratory tests confirming no hepatic disease worse than Child-Pugh class B in the past 30 days* Please indicate Child-Pugh classification if applicable: ☐ Child-Pugh class A ☐ Child-Pugh class B ☐ N/A Note: members with Child-Pugh class B will be limited to 150 mg daily dose for a maximum of 6 months
 irrespective of indication 5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No Diagnosis of osteoporosis Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)
If no , please specify contraindication and medical justification for use:
Prescriber Signature:
6. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) AND NSAID therapy ☐ Yes ☐ No
If no , please provide medical justification:

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exceeding 24 months of therapy per lifetime with elagolix $\ \square$ Yes $\ \square$ No
al justification for continued use beyond 24 months and date range or number of mont therapy thus far:

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