Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Orilissa (Elagolix)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of endometriosis confirmed by a workup/evaluation (versus presumptive treatment)? (Please attach documentation).

☐ Yes ☐ No

Q2. Does the patient have moderate to severe pain associated with endometriosis?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Is the patient pregnant?

☐ Yes ☐ No

Q5. Was the patient advised to use non-hormonal contraception during treatment with Orilissa and 1 week after discontinuing Orilissa?

☐ Yes ☐ No

Q6. Does the patient have known osteoporosis?

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Orilissa (Elagolix)

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q7. Does the patient have severe hepatic impairment (Child-Pugh Class C)?

☐ Yes ☐ No

Q8. Is Orilissa being requested in concurrent therapy with contraindicated medications, such as, strong organic anion transporting polypeptide (OATP) 1B1 inhibitors (for example systemic cyclosporine, gemfibrozil)?

☐ Yes ☐ No

Q9. Is the request from, or in consultation with, a gynecologist?

☐ Yes ☐ No

Q10. Has the patient experienced trial and failure and/or intolerance or contraindication to a 3 month course of a nonsteroidal anti-inflammatory drug (NSAID) AND a 3 month course of a contraceptive (either oral or non-oral) or depot medroxyprogesterone acetate?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 6 Months

Q12. Additional Information:

Prescriber Signature

Date

Updated 2018