



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q4. Is the patient pregnant?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q6. Does the patient have known osteoporosis?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q11. Requested Duration:

6 Months checkbox

Q12. Additional Information:

Prescriber Signature

Date

Updated 2018