Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Orilissa (Elagolix) Renewal

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. Has the patient previously received treatment with Orilissa for moderate to severe pain associated with endometriosis?

☐ Yes ☐ No

Q2. Is the patient pregnant?

☐ Yes ☐ No

Q3. Was the patient advised to use non-hormonal contraception during treatment with Orilissa and 1 week after discontinuing Orilissa?

☐ Yes ☐ No

Q4. Does the patient have known osteoporosis?

☐ Yes ☐ No

Q5. Has the impact to the patient's bone mineral density been considered?

☐ Yes ☐ No

Q6. Does the patient have severe hepatic impairment (Child-Pugh Class C)?

☐ Yes ☐ No

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Q7. 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

Q8. Does the patient have mild (Child-Pugh Class A) or no hepatic impairment and has been taking Orilissa at a dose of 150 MG once daily for a combined total duration of more than 24 months in their lifetime?

☐ Yes ☐ No

Q9. Does the patient have moderate hepatic impairment (Child-Pugh Class B) and has been taking Orilissa at a dose of 150 MG once daily for a combined total duration of more than 6 months in their lifetime?

☐ Yes ☐ No

Q10. Has the patient been taking Orilissa at a dose of 200 MG twice daily for a combined total duration of more than 6 months in their lifetime?

☐ Yes ☐ No

Q11. Has the patient responded to therapy? (Please include chart notes documenting response to therapy, including discussion of adverse events and compliance).

☐ Yes ☐ No

Q12. Requested Duration:

☐ 6 Months

Q13. Additional Information:

Prescriber Signature

Date

Updated 2018