Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Orilissa (Elagolix) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Orilissa (Elagolix) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
ORILISSA 150 MG TABLET	ORILISSA 200 MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 180 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of endometriosis in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have 1 claim for an NSAID and 1 claim for an oral contraceptive in the last 180 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of osteoporosis in the last 365 days? Y N

If the answer to this question is yes, denied..
If the answer to this question is no, go to question 6.

6. Does the patient have 1 claim for a strong OATP–1B1 inhibitor in the last 90 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis of severe hepatic impairment (Child-Pugh class C) in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 8.

8. Is the dose per day less than or equal to 150mg daily? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 12.

9. Does the patient have a diagnosis of moderate hepatic impairment (Child-Pugh class B) in the last 365 days? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, go to question 11.

10. Has the patient had more than 180 days of elagolix therapy in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 15.

11. Has the patient had less than 730 days of elagolix therapy in the last 730 days? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

12. Is the requested dose less than or equal to 400mg daily (dosed as 200mg twice daily)? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, denied.

13. Does the patient have a diagnosis of moderate hepatic impairment (Child-Pugh class B) in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Has the patient had more than 180 days of elagolix therapy in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 15.

15. Is the request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, approved for 180 days.

16. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 17.

17. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, go to question 18.

18. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 180 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (or Authorized) Signature	Date