



# Request for Prior Authorization Elagolix (Orilissa)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Initial Requests:**

Has pregnancy been ruled out?  Yes  No Date of pregnancy test: \_\_\_\_\_

Does patient have osteoporosis?  Yes  No

Does patient have severe hepatic impairment?  Yes  No

Is patient taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil)?  Yes  No

**Treatment Failures:**

**Preferred Oral NSAID Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**Preferred Continuous Hormonal Contraceptive Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**Preferred GnRH Agonist Trial:**

Name/dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason/medical contraindication: \_\_\_\_\_

**Renewal Requests:**

Provide documentation of improvement in symptoms: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.