CareSource Rxinnovations

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT**
**UTERINE DISORDERS PRIOR AUTHORIZATION REQUEST FORM**

*CareSource Pharmacy Prior Authorization Form*
**P.O. Box 8738**
**Dayton, OH 45401-8738**
**Fax: (866) 930-0019**

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

**Note:** This form must be completed by the prescribing provider.

*****All sections must be completed or the request will be returned.*****

| | |
|---|---|
| Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Office Contact |
| Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Prescriber's Address _____ | Date(s) of Service: _____<br>Start Date: _____ |
| Diagnosis: | Diagnosis Code: |

I attest the information on this form is accurate:

**Physician Signature:** _____ **Date:** _____

| Requested Medication | Strength | Quantity | Directions for Use |
|---|---|---|---|
| | | | |

## PA requirements for Myfembree (relugolix/estradiol/norethindrone acetate) tablet:

1. Member is 18 years of age or older? □ Yes □ No

2. Select one of the following diagnoses:
   - ☐ Menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females
   - ☐ Moderate to severe pain associated with endometriosis in premenopausal females

3. Negative pregnancy test in the past 30 days*? □ Yes □ No

4. Laboratory tests confirming no hepatic disease in the past 30 days*? □ Yes □ No

5. Provider attests that member has none of the following contraindications to therapy: □ Yes □ No
   - Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
   - Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR increased risk factors for hormone-sensitive malignancies
   - Diagnosis of osteoporosis
   - Undiagnosed abnormal uterine bleeding

If **no**, please specify contraindication and medical rationale for use:

_____

_____

**Prescriber Signature:** _____ **Date:** _____

6. Requested dose is 1 tablet (40/1/0.5 mg) per day? ☐ Yes ☐ No

If **no**, please explain_____

7. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) **AND** NSAIDs (required for endometriosis indication ONLY)? ☐ Yes ☐ No

If **no**, please provide medical rationale:

_____

_____

8. Member will **not** be exceeding 24 months of therapy per lifetime with Myfembree (relugolix/estradiol/norethindrone acetate) ? ☐ Yes ☐ No

If **yes**, provide medical rationale for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

***Note: Chart documentation will need to be provided for questions indicated with asterisk***

## PA requirements for ORIAHNN (elagolix/estradiol/norethindrone acetate):

1. Member is 18 years of age or older? ☐ Yes ☐ No

2. Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females? ☐ Yes ☐ No

3. Negative pregnancy test in the past 30 days*? ☐ Yes ☐ No

4. Laboratory tests confirming no hepatic disease in the past 30 days*? ☐ Yes ☐ No

5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
   - Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)
   - Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
   - Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR increased risk factors for hormone-sensitive malignancies
   - Diagnosis of osteoporosis
   - Undiagnosed abnormal uterine bleeding

If **no**, please specify contraindication and medical rationale for use:

_____

_____

**Prescriber Signature:** _____ **Date:** _____

6. Requested dose is 2 capsules (1 x 300/1/0.5 mg; 1 x 300 mg) per day? ☐ Yes ☐ No

If **no**, please explain:

_____

_____

7. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception)? ☐ Yes ☐ No

If **no**, please provide medical rationale:

_____

_____

8. Member will **not** be exceeding 24 months of therapy per lifetime with elagolix/estradiol/norethindrone acetate therapy? ☐ Yes ☐ No

If **yes**, provide medical rationale for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

***Note: Chart documentation will need to be provided for questions indicated with asterisk***

## PA requirements for ORILISSA (elagolix):

1. Member is 18 years of age or older? ☐ Yes ☐ No

2. Select one of the following diagnoses:
   - ☐ Moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia AND dose does not exceed 400 mg daily (6-month approval maximum)
   - ☐ Moderate to severe pain associated with endometriosis AND requested dose does not exceed 150 mg daily (1 year approval)

3. Negative pregnancy test in the past 30 days*? ☐ Yes ☐ No

4. Laboratory tests confirming no hepatic disease worse than Child-Pugh class B in the past 30 days*?
   - Please indicate Child-Pugh classification if applicable:
     ☐ Child-Pugh class A ☐ Child-Pugh class B ☐ N/A
     ***Note: Members with Child-Pugh class B will be limited to 150 mg daily dose for a maximum of 6 months irrespective of indication***

5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
   - Diagnosis of osteoporosis
   - Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

If **no**, please specify contraindication and medical rationale for use:

_____

_____

_____

**Prescriber Signature:** _____ **Date:** _____

6. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) **AND** NSAID therapy? ☐ Yes ☐ No

If **no**, please provide medical rationale:

_____

_____

7. Member will **not** be exceeding 24 months of therapy per lifetime with elagolix? ☐ Yes ☐ No

If **yes**, provide medical rationale for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

***Note: Chart documentation will need to be provided for questions indicated with asterisk***