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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATIONS ORILISSA™ (elagolix)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

ORILISSA™– to receive a SIX (6) months approval for this drug, complete the following questions.

1. The member has a confirmed diagnosis of endometriosis. **AND**

   ☐ Yes ☐ No

2. Is the member 18 years old or older? **AND**

   ☐ Yes ☐ No

3. The member has failed an adequate trial of the following therapies:
   - non-steroidal anti-inflammatory drugs (NSAIDs), **AND**
   - hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device), **AND**
   - gonadotropin-releasing hormone (GnRH) agonist (e.g., nafarelin [Synarel®], leuprolide [Lupron®], goserelin [Zoladex®]). **AND**

   ☐ Yes ☐ No

4. Elagolix is prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist. **AND**

   ☐ Yes ☐ No

5. Pregnancy is excluded prior to initiating treatment. **AND**

   ☐ Yes ☐ No

6. The member will use effective non-hormonal contraception during treatment with elagolix and 1 week after stopping therapy. **AND**

   ☐ Yes ☐ No

7. The member does not have osteoporosis as evident by a Z score > -1.5 at spine and femur (total hip). **AND**

   ☐ Yes ☐ No

8. The member does not have severe hepatic impairment (Child-Pugh C). **AND**

   ☐ Yes ☐ No

9. The member is not on concomitant strong organic anion transport polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil).

   ☐ Yes ☐ No

Member's Last Name: **Member's First Name:**

For renewal, complete the following questions to receive EIGHTEEN (18) months approval for the 150 mg tablet for a maximum duration of 24 months. No Renewal for the 200 mg tablet.

10. The member continues to meet the initial criteria. **AND**

☐ Yes ☐ No

11. The member is considered to have clinically meaningful response to treatment.

☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.