PRIOR AUTHORIZATION REQUEST

Orilissa

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the indication or diagnosis? [] Moderate to severe pain associated with endometriosis (If checked, go to 2) [] Other (If checked, no further questions)		
2	Does the patient have severe hepatic impairment or known osteoporosis? [If yes, no further questions.]	Yes	No
3	Is the medication being prescribed by or in consultation with an obstetrician-gynecologist?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If no, no further questions.]		
4	Is the patient pregnant? [If yes, no further questions.]	Yes	No
5	Is the request a continuation of therapy? [If yes, skip to question 12.]	Yes	No
6	Has the patient tried at least ONE of the following agents for at least 3 months: a contraceptive (for example, combination oral contraceptives, levonorgestrel-releasing intrauterine systems [for example, Mirena, Liletta]), an oral progesterone (for example, norethindrone tablets), or a depo-medroxyprogesterone injection, or has a contraindication to a contraceptive, an oral progesterone, or a depo-medroxyprogesterone injection? [If no, no further questions.] [If yes, skip to question 7.]	Yes	No
7	Does the patient have a documented intolerance to TWO other agents (for example, a contraceptive [such as, combination oral contraceptives, levonorgestrel-releasing intrauterine systems [for example, Mirena, Liletta], an oral progesterone [such as, norethindrone tablets], or a depo-medroxyprogesterone injection, or has a contraindication to a contraceptive, an oral progesterone, or a depo-medroxyprogesterone injection)? [If yes, skip to question 9.]	Yes	No
8	Has the patient previously used a gonadotropin-releasing hormone [GnRH] agonist (for example, Lupron Depot) for endometriosis? [If no, no further questions.]	Yes	No
9	Has the patient tried at least ONE of the following Non-steroidal anti-inflammatory drugs (NSAIDs) for 3 months: A) ibuprofen and B) naproxen? [If yes, skip to question 11.]	Yes	No
10	Does the patient have a documented intolerance to TWO other Non-steroidal anti-inflammatory drugs (NSAIDs) (for example, ibuprofen and naproxen)? [If no, no further questions.]	Yes	No
11	Does the dose of the requested medication exceed FDA approved label dosing for the indication? [No further questions.]	Yes	No
12	Does the patient have a documented clinically significant response, as determined by the prescriber? [If no, no further questions.]	Yes	No
13	Does the prescriber agree to monitor the patient's mental health status during treatment?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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