

Request for Prior Authorization for Oriahnn (elagolix/estradiol/norethindrone acetate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Oriahnn (elagolix/estradiol/norethindrone acetate) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Oriahnn (elagolix/estradiol/norethindrone acetate) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and the following criteria is met:

- The member is premenopausal and 18 years of age or older
- The member has heavy menstrual bleeding defined as having at least two menstrual cycles with greater than 80 mL of menstrual blood loss (MBL) as assessed by alkaline hematin (AH) method
- History of trial and failure, contraindication, or intolerance to one of the following:
 - Hysteroscopic myomectomy (if the fibroids are in an appropriate anatomic location)
 - Estrogen-progestin contraceptives (three month trial)
 - Progestins (e.g., norethindrone; IUD or oral therapy) (three month trial)
 - Tranexamic acid (three month trial)
- Prescribed by or in consultation with a obstetrics/gynecologist (OB/GYN) or reproductive endocrinologist
- Member does not have any contraindications to therapy such as: high risk of arterial, venous thrombotic, or thromboembolic disorder, pregnancy, known osteoporosis, uncontrolled hypertension, current or history of breast cancer or other hormonally-sensitive malignancies, known liver impairment or disease, undiagnosed abnormal uterine bleeding and organic anion transporting polypeptide (OATP) 1B1 inhibitors
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
 - Documentation of a positive clinical response to therapy demonstrated by a reduction in MBL volume or an improvement in hemoglobin (if applicable).
- **Reauthorization Duration of Approval:** 12 months
 - No reauthorization permitted after 24 months of therapy due to risk of potentially irreversible bone loss.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

**ORIAHNN (ELAGOLIX/ESTRADIOL/NORETHINDRONE ACETATE)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a JCODE: _____)

Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:
 Heavy menstrual bleeding (MBL) associated with uterine fibroids, Other: _____ ICD-10: _____
Is the member premenopausal? Yes No
Has the member had heavy menstrual bleeding during at least two menstrual cycles with greater than 80 mL of menstrual blood loss (MBL) as assessed by alkaline hematin (AH) method? Yes No
Has the member tried and failed, have a contraindication or intolerance to one of the following: Hysteroscopic myomectomy
 Estrogen-progestin contraceptives (*list below*) Progestin contraceptives (IUD or oral therapy) (*list below*) Tranexamic acid
Does the member have any contraindications to therapy? Yes No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a positive clinical response to therapy demonstrated by a reduction in MBL volume or an improvement in hemoglobin (if applicable)? Yes No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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Updated: 07/2020
DMMA Approved: 08/2020