

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



MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (808) 788-2949



Today's Date

/ /

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

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

Patient's Medicaid #	<input type="text"/>	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name		
Prescriber's IN License #	<input type="text"/>	Specialty	
Prescriber's NPI #	<input type="text"/>	Prescriber's Signature	
Return Fax #	<input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone #	<input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA	<input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable):	

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen

PA requirements for MYFEMBREE (relugolix/estradiol/norethindrone acetate):

- Member is 18 years of age or older ☐ Yes ☐ No
- 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
- Negative pregnancy test in the past 30 days* ☐ Yes ☐ No
- Laboratory tests confirming no hepatic disease in the past 30 days* ☐ Yes ☐ No
- 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 justification for use:

Prescriber Signature: _____

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 one of the following:

- Hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, intrauterine contraception (IUD)) for menorrhagia associated with uterine leiomyomas indication ONLY ☐ Yes ☐ No
- Hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, IUD) AND NSAID therapy for endometriosis indication ONLY ☐ Yes ☐ No

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

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

If **yes**, provide medical justification 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 justification for use:

Prescriber Signature: _____

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 justification:

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

If **yes**, provide medical justification 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 justification for use:

Prescriber Signature: _____

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 justification:

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

If **yes**, provide medical justification 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***

CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.