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: (800) 788-2949



Today's Date						
Note: This form must be complet	ed by the p	rescrib	ing pro	vider.		
All section:	s must be c	omplet	ed or t	ne request will be returned		
Patient's Medicaid #				of Birth / / /		
Patient's Name				riber's Name		
Prescriber's IN License #			Speci	alty		
Prescriber's NPI#			Prescriber's Signature			
Return Fax #		Return Phone # [
Check box if requesting retro-active PA			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).						
	04 41					
Requested Medication	Strength	Qua	ntity	Dosage Regimen		
Requested Medication	Strength	Qua	ntity	Dosage Regimen		
PA requirements for MYFEMBF	REE (reluge	olix/es				
•	REE (reluge	olix/es				
PA requirements for MYFEMBE 1. Member is 18 years of age or olde 2. Select one of the following diagno Menorrhagia associated	REE (reluger Yes Ses:	olix/es	tradio omas (fi			
PA requirements for MYFEMBE 1. Member is 18 years of age or olde 2. Select one of the following diagno Menorrhagia associated	REE (reluger Yes Ses: with uterine associated v	No leiomyc	tradio omas (fi	/norethindrone acetate): broids) in premenopausal females		
PA requirements for MYFEMBE 1. Member is 18 years of age or olde 2. Select one of the following diagno Menorrhagia associated Moderate to severe pain	REE (reluger Yes Ses: with uterine associated vertical associated vertical set 30 days*	olix/es No leiomycwith enc	tradio mas (fill dometri	/norethindrone acetate): broids) in premenopausal females basis in premenopausal females		

If no , please specify contraindication and medical rationale 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 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) \square Yes \square 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
BA I CA BELLININI CI DI CA DI LA COLLEGIA CA
PA requirements for ORIAHNN (elagolix/estradiol/norethindrone acetate):
PA requirements for ORIAHNN (elagolix/estradiol/norethindrone acetate): 1. Member is 18 years of age or older □ Yes □ No
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No 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 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
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No 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 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
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No 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 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
 Member is 18 years of age or older ☐ Yes ☐ No Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No 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 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
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
1. Member is 18 years of age or older
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

RXP0019 (4/23) Page 2 07.01.2023

If no , please explain
7. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) \square Yes \square 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 \square Yes \square 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 \square Yes \square 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:
6. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) AND NSAID therapy \square Yes \square No
If no , please provide medical rationale:
7. Member will not be exceeding 24 months of therapy per lifetime with elagolix \square Yes \square 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

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.

07.01.2023 Page 4