MHS PHARMACY BENEFIT

UTERINE DISORDERS PRIOR AUTHORIZATION REQUEST FORM

MHS 550 N. Meridian St. Suite 101 Indianapolis, IN, 46204-1208 Phone: (877) 647-4848 Fax: (866) 399-0929



Today's Date				
Note: This form must be complete	ed by the p	rescribir	ng pro	ovider.
	must be c	omplete	d or t	he request will be returned**
Patient's Medicaid #			Date	of Birth / / /
Patient's Name			Presc	riber's Name
Prescriber's IN License #			Speci	alty
Prescriber's NPI #			Presc	riber's Signature
Return Fax #				n Phone #
Check box if requesting retro-active PA	A			s) of service requested for active eligibility (if applicable):
	prior to 30 cal			to eligibility determination, but within established ubmission separately from current PA requests (dates o
Requested Medication	Strength	Quan	itity	Dosage Regimen
		linda da		
PA requirements for MYFEMBR	REE (relugo	olix/esti	radio	I/norethindrone acetate):
PA requirements for MYFEMBR 1. Member is 18 years of age or olde	, ,		radio	I/norethindrone acetate):
Member is 18 years of age or olde Select one of the following diagnos	r □ Yes □] No		
 1. Member is 18 years of age or olde 2. Select one of the following diagnos Menorrhagia associated v 	r □ Yes □ ses: with uterine	∃ No leiomyor	mas (fi	ibroids) in premenopausal females
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1. Member is 18 years of age or olde 2. Select one of the following diagnos	er Yes Ses: with uterine associated vectors st 30 days*	□ No leiomyor with endo □ Yes	mas (fi ometri □ No	ibroids) in premenopausal females osis in premenopausal females
1. Member is 18 years of age or olde 2. Select one of the following diagnos Menorrhagia associated of Moderate to severe pain and Moderate	er Yes ses: with uterine associated vertical terms associated ve	□ No leiomyor with endo □ Yes e in the p	mas (fi ometri □ No oast 30	ibroids) in premenopausal females osis in premenopausal females
1. Member is 18 years of age or olde 2. Select one of the following diagnos Menorrhagia associated of Moderate to severe pain and Moderate	ses: with uterine lassociated vertical disease none of the factors for, or performance of the store for the store for the store malign	□ No leiomyor with endo □ Yes e in the perevious Incer or o	mas (fi ometri No oast 30 contri history	ibroids) in premenopausal females osis in premenopausal females O days* Yes No aindications to therapy: Yes No

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Prescri	ber Signature:
6. Requ	ested dose is 1 tablet (40/1/0.5 mg) per day Yes No
lf no	, please explain
•	ous trial and failure of one of the following: Oriahnn (elagolix/estradiol/norethindrone acetate) for menorrhagia associated with uterine leiomyomas indication ONLY \square Yes \square No Orilissa (elagolix) for endometriosis indication ONLY \square Yes \square No
If no , pl	ease provide medical justification:
	ber will not be exceeding 24 months of therapy per lifetime with Myfembree olix/estradiol/norethindrone acetate) $\ \square$ Yes $\ \square$ No
	provide medical justification for continued use beyond 24 months and date range or number of months r has received therapy thus far:
*Note:	Chart documentation will need to be provided for questions indicated with asterisk
PA rec	uirements for ORIAHNN (elagolix/estradiol/norethindrone acetate):
1. Mem	ber is 18 years of age or older □ Yes □ No
-	nosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females \Box No
3. Nega	tive pregnancy test in the past 30 days* \square Yes \square No
4. Labo	ratory tests confirming no hepatic disease in the past 30 days* \square Yes \square No
_	der attests that member has none of the following contraindications to therapy: \Box Yes \Box No
5. Provi •	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
•	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
5. Provi	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
•	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

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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 \square Yes \square 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):
TA requirements for Oktabook (elagonix).
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* \square Yes \square 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 \square Yes \square No
If no , please provide medical justification:

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exceeding 24 months of therapy per lifetime with elagolix ☐ Yes ☐ No
al justification for continued use beyond 24 months and date range or number of montl I therapy thus far:

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