iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met:

1) Pregnancy has been ruled out; and
2) Patient does not have osteoporosis; and
3) Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
4) Requests for elagolix (Orilissa) will be considered under the following conditions:
    a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
    b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and
    c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
    d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms.
    e. Requests will be considered for a maximum of 24 months for the 150mg dose and 6 months for the 200mg dose; or
5) Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:
    a. Patient is premenopausal; and
    b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and
    c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and
    d. Patient has documentation of a previous trial and therapy failure with tranexamic acid.
    e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement in symptoms.
    f. Requests will be considered for a maximum of 24 months of treatment.

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Preferred **Non-Preferred**

☐ Oriahnn ☐ Myfembree ☐ Orilissa

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:

☐ **Initial Requests:**

Has pregnancy been ruled out? ☐ Yes ☐ No Date of pregnancy test:_____

Does patient have osteoporosis? ☐ Yes ☐ No

Does patient have severe hepatic impairment? ☐ Yes ☐ No

Is patient taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil)? ☐ Yes ☐ No

☐ **Orilissa**

Treatment Failures:

Preferred Oral NSAID Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

Preferred Continuous Hormonal Contraceptive Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

Preferred GnRH Agonist Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

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☐ **Oriahnn & Myfembree**

Is patient premenopausal? ☐ Yes ☐ No

Treatment Failures:

Preferred Continuous Hormonal Contraceptive Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

_____

Tranexamic Acid Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

_____

Medical or contraindication reason to override trial requirements: _____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

☐ **Renewal Requests:**

Provide documentation of improvement in symptoms:_____

_____

_____

Treatment start date:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*