OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
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Orilissa® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Does the patient have moderate to severe pain associated with endometriosis?	❑ Yes ❑ No
2. Does the patient have coexisting moderate hepatic impairment (Child-Pugh Class B)?	❑ Yes ❑ No
3. Has the patient received 6 or more months of therapy with Orilissa?	❑ Yes ❑ No
4. Has the patient received 24 or more months of therapy with Orilissa, or 6 months of therapy with Orilissa at 200mg twice daily?	❑ Yes ❑ No
5. Has the patient tried and had an inadequate response to therapy with hormonal contraceptives?	❑ Yes ❑ No
6. Does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to hormonal contraceptives?	❑ Yes ❑ No
7. Does the patient have osteoporosis?	❑ Yes ❑ No
8. Has the patient used Orilissa previously?	❑ Yes ❑ No
9. If yes to question 8, document how long the patient has already been on therapy with Orilissa: _____	
10. Does the patient have a history of low-trauma fracture or other risk for osteoporosis or bone loss?	❑ Yes ❑ No
11. If yes to question 10, does the patient meet both of the following? • Prescriber has assessed the patient's bone mineral density and states that the patient can continue therapy • Patient has not had a fragility fracture since starting therapy with Orilissa?	❑ Yes ❑ No
Quantity Limit:	
1. Is the quantity (dose) requested for documented titration purposes at the initiation of therapy (authorization for a 90 day titration period)?	❑ Yes ❑ No
2. Can the prescribed dose be achieved using a lesser quantity of a higher strength?	❑ Yes ❑ No
3. Does the requested quantity (dose) exceed the maximum FDA labeled dose (when specified), or the safest studied dose per the manufacturer's product insert?	❑ Yes ❑ No
4. If yes to question 3, will the prescriber submit documentation in support of therapy with a higher dose for the intended diagnosis? *Submitted documentation may include medical records OR fax form which reflects medical record documentation that shows the length of time the requested dose has been used, and what other medications and doses have been tried and failed.*	❑ Yes ❑ No

Orilissa® Prior Authorization Request Form (Page 2 of 2)

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern.