

**CAREFIRST**  
**Orilissa**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Orilissa.

**Patient Information**

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group:	<input type="text"/>
Patient DOB:	<input type="text"/>

**Physician Information**

Physician Name	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Addr.:	<input type="text"/>
City, St, Zip:	<input type="text"/>

**Drug Name (select from list of drugs shown)**

Orilissa 200mg Tablets (elagolix)    Orilissa 150mg Tablets (elagolix)    Orilissa (elagolix)

Quantity:	_____	Frequency:	_____	Strength:	_____
Route of Administration:	_____	Expected Length of Therapy:	_____		
Diagnosis:	_____	ICD Code:	_____		
Comments:	_____				

**Please check the appropriate answer for each applicable question.**

- |    |   |   |                          |   |                          |
|----|---|---|--------------------------|---|--------------------------|
| 1. | Is the requested drug being prescribed for the management of moderate to severe pain associated with endometriosis?   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Has the patient received the maximum recommended treatment course of 12 months of Lupron Depot or Lupaneta Pack OR 6 months of Synarel or Zoladex?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Has the patient previously received treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) or a relugolix-containing product (e.g., Myfembree)?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Will the patient receive 150 mg once daily of the requested drug?   | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Will the patient receive 200 mg twice daily of the requested drug?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Has the patient already received ANY of the following: A) Greater than or equal to 24 cumulative months of treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) and/or a relugolix-containing product (e.g., Myfembree), B) Greater than or equal to 6 months of treatment with Orilissa 200 mg twice daily? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | How many cumulative months has the patient received treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) and/or a relugolix-containing product (e.g., Myfembree)? Please check the total cumulative months of treatment.   |   |                          |   |                          |
|    | 12 months or less (If checked, no further questions)  |   | <input type="checkbox"/> |   |                          |
|    | 13 months (If checked, no further questions)  |   | <input type="checkbox"/> |   |                          |
|    | 14 months (If checked, no further questions)  |   | <input type="checkbox"/> |   |                          |
|    | 15 months (If checked, no further questions)  |   | <input type="checkbox"/> |   |                          |
|    | 16 months (If checked, no further questions)  |   | <input type="checkbox"/> |   |                          |

- |   |                          |
|---|--------------------------|
| 17 months (If checked, no further questions)            | <input type="checkbox"/> |
| 18 months (If checked, no further questions)            | <input type="checkbox"/> |
| 19 months (If checked, no further questions)            | <input type="checkbox"/> |
| 20 months (If checked, no further questions)            | <input type="checkbox"/> |
| 21 months (If checked, no further questions)            | <input type="checkbox"/> |
| 22 months (If checked, no further questions)            | <input type="checkbox"/> |
| 23 months (If checked, no further questions)            | <input type="checkbox"/> |
| 24 months or greater (If checked, no further questions) | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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**Prescriber (Or Authorized) Signature and Date**

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