BlueCross BlueShield Federal Employee Program

ORILISSA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Orilissa (elagolix)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and indicate quantity:

❑150mg	**Will the patient need more than 84 tablets every 84 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ tablets every 84 days**
❑200mg	**Will the patient need more than 168 tablets every 84 days? ❑Yes* ❑No** ***If YES*, please specify the requested quantity: _____ tablets every 84 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is this request for brand or generic? ❑Brand ❑Generic
2. Is the patient assigned female at birth? ❑Yes ❑No
3. What is the patient's diagnosis?
   ❑Moderate to severe pain associated with endometriosis ❑Other ***(please specify)***: _____
4. Does the patient have a diagnosis of osteoporosis? ❑Yes ❑No
5. Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, is the patient currently pregnant? ❑Yes ❑No*
   If NO, will the patient be advised to use effective non-hormonal contraception while on Orilissa therapy and for 28 days after discontinuing Orilissa? ❑Yes ❑No
6. Does the prescriber agree to monitor for suicidal ideation and mood disorders? ❑Yes ❑No
7. Is the prescriber an obstetrician-gynecologist (OB-GYN) or is this medication being prescribed in consultation with an OB-GYN? ❑Yes ❑No
8. Has the patient been on this medication continuously for the last **3 months** excluding samples? ***Please select answer below:***
   ❑**INITIATION** of therapy, please answer the following questions:
   a. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
   b. Has there been a baseline evaluation of the condition using a validated tool such as: the *Biberoglu and Behrman (B&B) Scale, the Composite Pelvic Signs and Symptoms Score (CPSSS), *Visual Analog Scale (VAS), *Numerical Rating Scale (NRS), or other qualified assessment tool? ❑Yes ❑No
      ***B&B:* https://www.researchgate.net/figure/Biberoglu-and-Behrman-score_fig2_232262472**
      ***VAS:* http://img.medscape.com/article/742/580/VAS.pdf**
      ***NRS:* https://www.sralab.org/sites/default/files/2017-07/Numeric%20Pain%20Rating%20Scale%20Instructions.pdf**
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of NSAIDs **OR** oral contraceptives? ❑Yes ❑No

   ❑**CONTINUATION (PA renewal)** of therapy, please answer the following questions:
   a. Has there been a documented improvement in endometriosis-related pain? ❑Yes ❑No
   b. Does the patient have moderate to severe hepatic impairment (Child-Pugh Class B or C)? ❑Yes ❑No