

# ELAGOLIX RELUGOLIX PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis: <input type="checkbox"/> Moderate to severe pain associated with endometriosis <input type="checkbox"/> Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____ 3. Will the patient be using the requested agent in combination with another GnRH antagonist agent targeted in this program (e.g., elagolix, relugolix) for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is the patient premenopausal (e.g., less than 12 months since last menstrual period)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Has the patient's bone health been assessed AND allows for initiating therapy with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Has the patient tried and had an inadequate response to ONE prerequisite agent (i.e., hormonal contraceptive, NSAID [including COX-II inhibitors]) used in the treatment of the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have an intolerance or hypersensitivity to ONE prerequisite agent (i.e., hormonal contraceptive, NSAID [including COX-II inhibitors]) used in the treatment of the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain intolerance/hypersensitivity: _____ _____ If no, does the patient have an FDA labeled contraindication to ALL prerequisite therapies (i.e., hormonal contraceptives [i.e., oral, topical patches, implants, injections, IUD], NSAIDs [including COX-II inhibitors]) used in the treatment of the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<b>For all requests:</b>			
7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____			
<b>For heavy menstrual bleeding associated with uterine leiomyomas (fibroids) requests:</b>			
8. Has the patient's diagnosis of uterine fibroids been confirmed via imaging (e.g., ultrasound)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Has the patient had a hysterectomy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>For Orilissa requests:</b>			
10. Does the patient have coexisting moderate hepatic impairment (Child-Pugh [CP]/ Child-Turcotte-Pugh [CTP] Class B)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Is the patient initiating therapy with the requested agent and strength? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate the number of months the patient has been on therapy: _____			
<b>For Myfembree and Oriahnn requests:</b>			
12. Is the patient initiating therapy with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate the number of months the patient has been on therapy: _____			
<b>For renewal requests:</b>			
13. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Has the patient's bone health been assessed AND allows for continued therapy with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Has the patient had a fragility fracture since starting therapy with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121  <b>TOLL FREE</b>		<b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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