

Elagolix Relugolix Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
12-15-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Orilissa	elagolix sodium tab	150 MG ; 200 MG	M ; N ; O ; Y	N		
Oriahnn	elagolix-estradiol-noreth	300-1-0.5 & 300 MG	M ; N ; O ; Y	N		
Myfembree	relugolix-estradiol-norethindrone acetate tab	40-1-0.5 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Myfembree	relugolix-estradiol-norethindrone acetate tab	40-1-0.5 MG	30	Tablets	30	DAYS			
Oriahnn	Elagolix-Estradiol-Noreth 300-1-0.5MG & Elagolix 300MG Cap Pack	300-1-0.5 & 300 MG	56	Capsules	28	DAYS			
Orilissa	Elagolix Sodium Tab 150 MG (Base Equiv)	150 MG	30	Tablets	30	DAYS			
Orilissa	Elagolix Sodium Tab 200 MG (Base Equiv)	200 MG	60	Tablets	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Myfembree	relugolix-estradiol-norethindrone acetate tab	40-1-0.5 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Oriahnn	elagolix-estradiol-noreth	300-1-0.5 & 300 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Orilissa	elagolix sodium tab	150 MG ; 200 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Myfembree	relugolix-estradiol-norethindrone acetate tab	40-1-0.5 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
OriaHnn	Elagolix-Estrad-Noreth 300-1-0.5MG & Elagolix 300MG Cap Pack	300-1-0.5 & 300 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Orilissa	Elagolix Sodium Tab 150 MG (Base Equiv)	150 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Orilissa	Elagolix Sodium Tab 200 MG (Base Equiv)	200 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Myfembree	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and BOTH of the following: <ol style="list-style-type: none"> 1. The patient’s diagnosis of uterine fibroids was confirmed via imaging (e.g., ultrasound) AND 2. The patient has NOT had a hysterectomy OR B. The patient has a diagnosis of moderate to severe pain associated with endometriosis AND 2. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 3. The patient’s bone health has been assessed AND allows for initiating therapy with the requested agent AND 4. The patient has ONE of the following: <ol style="list-style-type: none"> A. 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 OR B. Has 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 OR C. Has 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 AND 5. The patient will NOT be using the requested agent in combination with another GnRH antagonist agent targeted in this program (e.g., elagolix, relugolix) for the requested indication AND 6. The patient does NOT have any FDA labeled contraindications to the requested agent AND 7. ONE of the following: <ol style="list-style-type: none"> A. The patient is initiating therapy with the requested agent OR B. The patient is NOT initiating therapy with the requested agent and BOTH of the following: <ol style="list-style-type: none"> 1. There is support confirming the number of months the patient has been on therapy AND 2. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime

Module	Clinical Criteria for Approval
	<p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM], with a lifetime maximum of 24 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 3. The patient has had clinical benefit with the requested agent AND 4. The patient's bone health has been assessed AND allows for continued therapy with the requested agent AND

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	<p>5. The patient has NOT had a fragility fracture since starting therapy with the requested agent AND</p> <p>6. The patient will NOT be using the requested agent in combination with another elagolix or relugolix agent AND</p> <p>7. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>8. BOTH of the following:</p> <ul style="list-style-type: none"> A. There is support confirming the number of months the patient has been on therapy AND B. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM], with a lifetime maximum of 24 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>
OriaHnn	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) AND 2. The patient’s diagnosis of uterine fibroids was confirmed via imaging (e.g., ultrasound) AND 3. The patient has NOT had a hysterectomy AND 4. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 5. The patient’s bone health has been assessed AND allows for initiating therapy with the requested agent AND 6. The patient has ONE of the following: <ul style="list-style-type: none"> A. 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 OR B. 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 OR C. 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 AND 7. The patient will NOT be using the requested agent in combination with another elagolix or relugolix agent AND 8. The patient does NOT have any FDA labeled contraindications to the requested agent AND 9. ONE of the following: <ul style="list-style-type: none"> A. The patient is initiating therapy with the requested agent OR B. The patient is NOT initiating therapy with the requested agent and BOTH of the following: <ol style="list-style-type: none"> 1. There is support confirming the number of months the patient has been on therapy AND 2. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime <p>Length of Approval:</p>

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	<p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM], with a lifetime maximum of 24 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 3. The patient has had clinical benefit with the requested agent AND 4. The patient's bone health has been assessed AND allows for continued therapy with the requested agent AND 5. The patient has NOT had a fragility fracture since starting therapy with the requested agent AND

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	<p>6. The patient will NOT be using the requested agent in combination with another elagolix or relugolix agent AND</p> <p>7. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>8. BOTH of the following:</p> <p>A. There is support confirming the number of months the patient has been on therapy AND</p> <p>B. The total duration of treatment with the requested agent has NOT exceeded 24 months per lifetime</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM], with a lifetime maximum of 24 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>
Orilissa	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of moderate to severe pain associated with endometriosis AND 2. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 3. The patient has ONE of the following: <ol style="list-style-type: none"> A. 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 OR B. 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 OR C. 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 AND 4. The patient's bone health has been assessed AND allows for initiating therapy with the requested agent AND 5. The patient will NOT be using the requested agent in combination with another elagolix or relugolix agent AND 6. The patient does NOT have any FDA labeled contraindications to the requested agent AND 7. ONE of the following: <ol style="list-style-type: none"> A. The patient does NOT have coexisting moderate hepatic impairment (Child-Pugh [CP] Class B) AND ONE of the following: <ol style="list-style-type: none"> 1. The patient is initiating therapy with the requested agent and strength OR 2. The patient is NOT initiating therapy with the requested agent and strength and BOTH of the following: <ol style="list-style-type: none"> A. There is support confirming the number of months the patient has been on therapy AND B. ONE of the following: <ol style="list-style-type: none"> 1. The requested strength is 150 mg AND the total duration of treatment with the requested strength has NOT exceeded 24 months per lifetime OR 2. The requested strength is 200 mg AND the total duration of treatment with the requested strength has NOT exceeded 6 months per lifetime OR

Module	Clinical Criteria for Approval
	<p data-bbox="354 180 1417 527"> B. The patient does have coexisting moderate hepatic impairment (Child-Pugh [CP] Class B) AND BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="467 239 997 268">1. The requested strength is 150 mg AND <li data-bbox="467 270 1417 527">2. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="565 300 1357 354">A. The patient is initiating therapy with the requested agent and strength OR <li data-bbox="565 357 1417 527">B. The patient is NOT initiating therapy with the requested agent and strength AND BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="639 415 1369 470">1. There is support confirming the number of months the patient has been on therapy AND <li data-bbox="639 472 1321 527">2. The total duration of treatment with the requested strength has NOT exceeded 6 months per lifetime </p> <p data-bbox="228 569 500 598">Length of Approval:</p> <p data-bbox="228 632 1369 835"> BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM] with a lifetime maximum of 24 months with the 150 mg without coexisting moderate hepatic impairment; up to 6 months[at least 3 months for NM] with a lifetime maximum of 6 months with the 150 mg with coexisting moderate hepatic impairment; up to 6 months[at least 3 months for NM] with a lifetime maximum of 6 months with the 200 mg </p> <p data-bbox="228 873 1084 903">NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p data-bbox="228 1003 1192 1033">The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> <li data-bbox="277 1068 737 1098">1. The member resides in Ohio AND <li data-bbox="277 1100 1417 1535">2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> <li data-bbox="354 1129 1373 1184">A. The patient does NOT have any FDA labeled contraindications to the requested agent AND <li data-bbox="354 1186 1417 1535">B. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="467 1215 1378 1270">1. The patient has another FDA labeled indication for the requested agent and route of administration OR <li data-bbox="467 1272 1406 1327">2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR <li data-bbox="467 1329 1401 1535">3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p data-bbox="228 1572 1396 1627">Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p data-bbox="228 1665 1382 1753">Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p data-bbox="228 1791 500 1820">Length of Approval:</p> <p data-bbox="228 1854 570 1913"> BCBSOK: 36 months ALL other plans: 12 months </p>

Module	Clinical Criteria for Approval
	<p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan’s Prior Authorization process (*please note requests for 200 mg strength should always be reviewed under initial criteria) (Note: patients not previously approved for the requested agent will require initial evaluation review) AND 2. The patient is premenopausal (e.g., less than 12 months since last menstrual period) AND 3. The patient has had clinical benefit with the requested agent AND 4. The patient’s bone health has been assessed AND allows for continued therapy with the requested agent AND 5. The patient has NOT had a fragility fracture since starting therapy with the requested agent AND 6. The patient will NOT be using the requested agent in combination with another elagolix or relugolix agent AND 7. The patient does NOT have any FDA labeled contraindications to the requested agent AND 8. BOTH of the following: <ol style="list-style-type: none"> A. There is support confirming the number of months the patient has been on therapy with the requested agent and strength AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient does NOT have coexisting moderate hepatic impairment (Child-Pugh [CP] Class B) AND the total duration of treatment with the requested strength has NOT exceeded 24 months per lifetime OR 2. The patient does have coexisting moderate hepatic impairment (Child-Pugh [CP] Class B) AND the total duration of treatment with the requested strength has NOT exceeded 6 months per lifetime <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: up to 6 months [at least 3 months for NM] with a lifetime maximum of 24 months with the 150 mg without coexisting moderate hepatic impairment; up to 6 months[at least 3 months for NM] with a lifetime maximum of 6 months with the 150 mg with coexisting moderate hepatic impairment; up to 6 months[at least 3 months for NM] with a lifetime maximum of 6 months with the 200 mg</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit <p>Length of Approval:</p> <p>BCBSIL plans: 12 months</p> <p>All other plans: Myfembree and Oriahnn: up to 6 months with a lifetime maximum of 24 months.</p>

Module	Clinical Criteria for Approval
	Orilissa: up to 6 months[at least 3 months for MT/NM] with a lifetime maximum of 24 months with the 150 mg dose without coexisting moderate hepatic impairment; up to 6 months[at least 3 months for MT/NM] with a lifetime maximum of 6 months with the 150 mg dose with coexisting moderate hepatic impairment; up to 6 months [at least 3 months for MT/NM] with a lifetime maximum of 6 months with the 200 mg dose