SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (check applicable box below)

❑ **Myfembree®** (relugolix, estradiol, and norethindrone)	❑ **Oriahnn®** (elagolix, estradiol, and norethindrone)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit:

- Oriahnn: 56 tablets per 28 days
- Myfembree: 30 tablets per 30 days

Total collective approval duration not to exceed 24 months for all GnRH antagonist products

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. Tosupport each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ Diagnosis: Uterine Leiomyomas (Fibroids) – Myfembree or Oriahnn

Initial Authorization: 12 months

- ❑ Member is premenopausal
- ❑ Member is 18 years of age or older
- ❑ Medication is being prescribed by or in consultation with a specialist in gynecology or reproductive health
- ❑ Member has uterine leiomyomas (fibroids)
- ❑ Member is using for the management of heavy menstrual bleeding
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, history of thrombotic or thromboembolic disorders, uncontrolled hypertension, or hepatic impairment/disease
- ❑ Member has history of inadequate response to the following therapies, tried for at least three (3) months each **(must submit chart note documentation of all therapy failures)**:
  - ❑ Oral contraceptives **OR** a selective progesterone receptor modulator **OR** intrauterine device
  - ❑ NSAIDs (non-steroidal anti-inflammatory drugs)
  - ❑ tranexamic acid 650 mg

OR

  - ❑ Member has had surgery for uterine fibroids (i.e., ablation, myomectomy) and has persistent symptoms **(must submit documentation of date/type of surgery or procedure)**

❑ Diagnosis: Uterine Leiomyomas (Fibroids) – Myfembree or Oriahnn

Reauthorization: 12 months

Note: Maximum: 24-month collective approval per lifetime for ALL GnRH antagonist medications due to risk of irreversible bone loss

- ❑ Member has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life)
- ❑ Member is compliant on prescribed medication (Oriahnn® or Myfembree®) **(verified by pharmacy paid claims)**
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, history of thrombotic or thromboembolic disorders, uncontrolled hypertension, or hepatic impairment/disease
- ❑ Treatment duration has not exceeded a total of 24 months **(verified by pharmacy paid claims)**

❑ Diagnosis: Endometriosis – Myfembree only

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Medication is being prescribed by or in consultation with a specialist in gynecology or reproductive health
- ❑ Diagnosis of moderate to severe pain associated with endometriosis
- ❑ Diagnosis of endometriosis has been confirmed by direct visualization during surgery and/or histology

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- ❑ Member has history of inadequate response to the following therapies, tried for at least three (3) months each **(must submit chart note documentation of all therapy failures)**:
  - ❑ NSAIDs (non-steroidal anti-inflammatory drugs)
  - ❑ Combination (estrogen/progesterone) oral contraceptive
  - ❑ Progestins

OR

  - ❑ Member has had surgical ablation to prevent recurrence
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, history of thrombotic or thromboembolic disorders, uncontrolled hypertension, or hepatic impairment/disease

❑ **Diagnosis: Endometriosis – Myfembree only**
Reauthorization: 12 months
Note: Maximum: 24-month collective approval per lifetime for ALL GnRH antagonist medications due to risk of irreversible bone loss

- ❑ Member has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and non-menstrual pelvic pain)
- ❑ Member does **NOT** have any contraindications to therapy including osteoporosis, history of thrombotic or thromboembolic disorders, uncontrolled hypertension, or hepatic impairment/disease
- ❑ Treatment duration has not exceeded a total of 24 months **(verified by pharmacy paid claims)**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~8/20/2020;~~ 11/18/2022
REVISED/UPDATED/REFORMATTED: ~~12/7/2020; 9/10/2021, 11/8/2021; 11/22/2021; 11/30/2022; 9/26/2023;~~ **9/5/2024**