

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)

<input type="checkbox"/> Myfembree® (relugolix, estradiol, and norethindrone)	<input type="checkbox"/> Oriahnn® (elagolix, estradiol, and norethindrone)
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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: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

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. To support 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**)

Medication being provided by Specialty Pharmacy - PropriumRx

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.****