Prior Authorization Form

CAREFIRST

Oriahnn

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Oriahnn.

Drug Name (select from list of drugs shown)

Oriahnn (elagolix-estradiol-norethindrone acetate)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal patient?	Y N
[If no, then no further questions.]	
2. Has the patient previously received treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) or a relugolix-containing product (e.g., Myfembree)?	Y N
[If no, then no further questions.]	
3. Has the patient already received any of the following: A) Greater than or equal to 24 cumulative months of treatment	Y N

with elagolix-containing products (e.g., Oriahnn, Orilissa) and/or relugolix-containing products (e.g., Myfembree), B) Greater than or equal to 6 months of treatment with Orilissa 200mg twice daily?	
[If yes, then no further questions.]	
4. How many cumulative months has the patient received treatment with elagolix-containing products (e.g., Oriahnn, Orilissa) and/or relugolix-containing products (e.g., Myfembree)?	
[Note: Please check the total cumulative months of treatment.]	
12 months or less(if checked, no further questions)	☐
13 months (if checked, no further questions)	☐
14 months (if checked, no further questions)	☐
15 months (if checked, no further questions)	☐
16 months (if checked, no further questions)	☐
17 months (if checked, no further questions)	☐
18 months (if checked, no further questions)	☐
19 months (if checked, no further questions)	☐
20 months (if checked, no further questions)	☐
21 months (if checked, no further questions)	☐
22 months (if checked, no further questions)	☐
23 months (if checked, no further questions)	☐
24 months or greater (if checked, no further question)	☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date