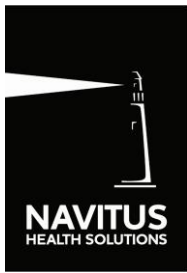




TEXAS MEDICAID
Clinical Edit Prior Authorization
elagolix, estradiol and norethindrone
(ORIAHNN)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA	
<input type="checkbox"/> Indicate Primary Diagnosis: _____ ICD 10 Code: _____	
1. Is the client greater than or equal to (\geq) 18 years of age? <input type="checkbox"/> Yes (Go to #2) <input type="checkbox"/> No (Deny)	
2. Does the client have a diagnosis of uterine leiomyoma in the last 730 days? <input type="checkbox"/> Yes (Go to #3) <input type="checkbox"/> No (Deny)	
3. Does the client have 1 claim for a contraceptive agent in the last 180 days? <input type="checkbox"/> Yes (Go to #4) <input type="checkbox"/> No (Deny)	
4. Does the client have a diagnosis of osteoporosis in the last 365 days? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #5)	
5. Does the client have 1 claim for a strong OATP-1B1 inhibitor in the last 90 days? Examples of OATP-1B1 inhibitors include cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), gemfibrozil (LOPID), PROMACTA, rifampin (RIFADIN), and RIFAMATE <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #6)	



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<p>6. Does the client have a diagnosis of hepatic impairment in the last 365 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #7)</p>
<p>7. Does the client have a history of arterial, venous thrombotic or thromboembolic disorder in the last 730 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #8)</p>
<p>8. Is the client greater than (>) 35 years of age?</p> <p><input type="checkbox"/> Yes (Go to #9) <input type="checkbox"/> No (Go to #10)</p>
<p>9. Is the client a current smoker?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #10)</p>
<p>10. Does the client have a diagnosis of uncontrolled hypertension in the last 180 days? [Manual Step]</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #11)</p>
<p>11. Has the client had a confirmed suicide attempt in the last 365 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #12)</p>
<p>12. Does the client have a diagnosis of breast cancer or other hormonally sensitive cancer in the last 365 days?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #13)</p>
<p>13. Is the dose per day less than or equal to (\leq) 2 capsules daily?</p> <p><input type="checkbox"/> Yes (Go to #14) <input type="checkbox"/> No (Deny)</p>
<p>14. Has the client had more than (>) 24 months of elagolix/estradiol/norethindrone therapy?</p> <p><input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Approve – 365 days)</p>
STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553
<p>Prescriber Signature: _____ Date: _____</p>

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.