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

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of uterine leiomyoma in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have 1 claim for a contraceptive agent in the last 180 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a diagnosis of osteoporosis in the last 365 days?

   ☐ Yes (Deny) ☐ 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

   ☐ Yes (Deny) ☐ No (Go to #6)

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6. Does the client have a diagnosis of hepatic impairment in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a history of arterial, venous thrombotic or thromboembolic disorder in the last 730 days?

☐ Yes (Deny) ☐ No (Go to #8)

8. Is the client greater than (>) 35 years of age?

☐ Yes (Go to #9) ☐ No (Go to #10)

9. Is the client a current smoker?

☐ Yes (Deny) ☐ No (Go to #10)

10. Does the client have a diagnosis of uncontrolled hypertension in the last 180 days? [Manual Step]

☐ Yes (Deny) ☐ No (Go to #11)

11. Has the client had a confirmed suicide attempt in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #12)

12. Does the client have a diagnosis of breast cancer or other hormonally sensitive cancer in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #13)

13. Is the dose per day less than or equal to (≤) 2 capsules daily?

☐ Yes (Go to #14) ☐ No (Deny)

14. Has the client had more than (>) 24 months of elagolix/estradiol/norethindrone therapy?

☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

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.