Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Gonadotropin Releasing Hormone (GnRH) Receptor Antagonists

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

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

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

7. Does the member have a diagnosis of uterine leiomyoma in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No (And the request is for MYFEMBREE)
  (Go to #8)
- ◯ No (And the request is for ORIAHNN, Deny)
  (Go to #8)

8. Does the member have a diagnosis of endometriosis in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Is this an initial request?

- ◯ Yes
  (Go to #11)
- ◯ No
  (Go to #10)

10. Has the member had therapy with a contraceptive agent in the last 180 days? (Concomitant use of hormonal contraceptives should be avoided.)

- ◯ Yes (Deny)
  (Go to #11)
- ◯ No
  (Go to #12)

11. Has the member had at least 90 days therapy with a contraceptive agent in the last 180 days?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Does the member have a diagnosis of osteoporosis in the last 365 days?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No (And the request is for Oriahnn)
  (Go to #13)
- ◯ No (And the request is for Myfembree)
  (Go to #14)

13. Does the member have one (1) claim for a strong organic anion transporting polypeptide 1B1 (OATP-1B1) inhibitor in the last 90 days?

    Examples of OATP-1B1 inhibitors include: cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), gemfibrozil (LOPID), PROMACTA, and rifampin (RIFADIN).

- ◯ Yes (Deny)
  (Go to #14)
- ◯ No
  (Go to #14)

14. Does the member have a diagnosis of hepatic impairment in the last 365 days?

- ◯ Yes (Deny)
  (Go to #15)
- ◯ No
  (Go to #15)

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

- ◯ Yes (Deny)
  (Go to #16)
- ◯ No
  (Go to #16)

16. Is the member greater than (>) 35 years of age?

- ◯ Yes
  (Go to #17)
- ◯ No
  (Go to #18)

17. Is the member a current smoker?

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Does the member have a diagnosis of uncontrolled hypertension in the last 180 days? [Manual]

- ◯ Yes (Deny)
  (Go to #19)
- ◯ No
  (Go to #19)

19. Has the member had a confirmed suicide attempt in the last 365 days?

- ◯ Yes (Deny)
  (Go to #20)
- ◯ No
  (Go to #20)

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

- ◯ Yes (Deny)
  (Go to #21)
- ◯ No
  (Go to #21)

21. If the request is for Oriahnn, is the dose per day less than or equal to (≤) two (2) capsules daily? If the request is for Myfembree, is the dose per day less than or equal to (≤) one (1) tablet daily?

- ◯ Yes
  (Go to #22)
- ◯ No (Deny)
  (Go to #22)

22. Has the member had more than (>) 24 months of elagolix/relugolix-estradiol-norethindrone therapy?

- ◯ Yes (Deny)
  (Go to #23)
- ◯ No (Approve - 365 days)
  (Go to #23)

Additional Information

23. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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