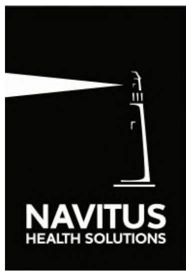


TEXAS MEDICAID
Clinical Edit Prior Authorization
elagolix (ORILISSA)

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: COMPLETE REQUIRED 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 endometriosis in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have one (1) claim for a nonsteroidal anti-inflammatory drug (NSAID) **AND** one (1) claim for an oral contraceptive 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)

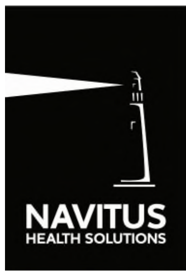
5. Does the client have one (1) claim for a strong OATP–1B1 inhibitor in the last 90 days?

   Examples include cyclosporine (GENGRAF, NEORAL, SANDIMMUNE) and gemfibrozil (LOPID).

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a diagnosis of severe hepatic impairment (Child-Pugh class C) in the last 365 days? [Manual Step]

   ☐ Yes (Deny) ☐ No (Go to #7)



7. Is the dose per day less than or equal to (≤) 150mg daily?

   ☐ Yes (Go to #8) ☐ No (Go to #11)

8. Does the client have a diagnosis of moderate hepatic impairment (Child-Pugh class B) in the last 365 days? [Manual Step]

   ☐ Yes (Go to #9) ☐ No (Go to #10)

9. Has the client had more than (>) 180 days of elagolix therapy in the last 730 days?

   ☐ Yes (Deny) ☐ No (Approve – 180 days)

10. Has the client had less than (<) 730 days of elagolix therapy in the last 730 days?

    ☐ Yes (Approve – 180 days) ☐ No (Deny)

11. Is the requested dose less than or equal to (≤) 400mg daily (dosed as 200mg twice daily)?

    ☐ Yes (Go to #12) ☐ No (Deny)

12. Does the client have a diagnosis of moderate hepatic impairment (Child-Pugh class B) in the last 365 days? [Manual Step]

    ☐ Yes (Deny) ☐ No (Go to #13)

13. Has the client had more than (>) 180 days of elagolix therapy in the last 730 days?

    ☐ Yes (Deny) ☐ No (Approve – 180 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.