



Please complete ALL information below and fax your request to 1-888-671-5285

Orilissa™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable <input type="checkbox"/> Check if request is for continuation of therapy		Directions for Use:

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Moderate to severe pain associated with endometriosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Clinical information: Has the patient had surgical ablation to prevent recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Select the medications the patient has had a history of inadequate pain control response (following a trial of at least 3 months), intolerance, or contraindication to: <input type="checkbox"/> Combination (estrogen/progesterone) oral contraceptive <input type="checkbox"/> Danazol <input type="checkbox"/> Progestins
Reauthorization: For reauthorization requests, answer the following: Has the patient had improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and non-menstrual pelvic pain)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the treatment duration of Orilissa exceeded a total of 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity limit requests: What is the quantity requested per DAY? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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