OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Orilissa™ Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe pain associated with endometriosis
❑ Other diagnosis: _____ ICD-10 Code(s):_____

Clinical information:

Has the patient had surgical ablation to prevent recurrence? ❑ **Yes** ❑ **No**
Is the patient premenopausal? ❑ **Yes** ❑ **No**
Was Orilissa prescribed by or in consultation with an Obstetrics/Gynecologist (OB/GYN) OR reproductive endocrinologist? ❑ **Yes** ❑ **No**

Medication history:

Select if the patient has had a **history of inadequate pain control response** to the following (must indicate length of trial):

❑ Combination (estrogen/progesterone) oral contraceptive Duration of trial: ❑ ≥ 3 months ❑ ≥ 6 months
❑ Danazol Duration of trial: ❑ ≥ 3 months ❑ ≥ 6 months
❑ Progestins Duration of trial: ❑ ≥ 3 months ❑ ≥ 6 months
❑ Two analgesics (e.g., ibuprofen, meloxicam, naproxen) Duration of trial: ❑ ≥ 3 months ❑ ≥ 6 months

Select if the patient has had a history of **intolerance or contraindication** to the following:

❑ Combination (estrogen/progesterone) oral contraceptive
❑ Danazol
❑ Progestins
❑ Two analgesics (e.g., ibuprofen, meloxicam, naproxen)

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)? ❑ **Yes** ❑ **No**
Has impact to bone mineral density been considered? ❑ **Yes** ❑ **No**
Has the treatment duration of Orilissa exceeded a total of 24 months? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ 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)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Orilissa™ Prior Authorization Request Form (Page 2 of 2)

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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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.