INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
UTERINE DISORDERS PRIOR AUTHORIZATION REQUEST FORM

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Humana
Healthy Horizons®
in Indiana

Today's Date
☐☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen

PA requirements for MYFEMBREE (relugolix/estradiol/norethindrone acetate):

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Select one of the following diagnoses:
   - ☐ Menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females
   - ☐ Moderate to severe pain associated with endometriosis in premenopausal females

3. Negative pregnancy test in the past 30 days* ☐ Yes ☐ No

4. Laboratory tests confirming no hepatic disease in the past 30 days* ☐ Yes ☐ No

5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
   - Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
   - Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR increased risk factors for hormone-sensitive malignancies
   - Diagnosis of osteoporosis
   - Undiagnosed abnormal uterine bleeding

If **no**, please specify contraindication and medical justification for use:

_____

_____

Prescriber Signature: _____

6. Requested dose is 1 tablet (40/1/0.5 mg) per day ☐ Yes ☐ No

If **no**, please explain_____

7. Previous trial and failure of one of the following:
   - Hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, intrauterine contraception (IUD)) for menorrhagia associated with uterine leiomyomas indication ONLY ☐ Yes ☐ No
   - Hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, IUD) AND NSAID therapy for endometriosis indication ONLY ☐ Yes ☐ No

If **no**, please provide medical justification:

_____

_____

8. Member will not be exceeding 24 months of therapy per lifetime with Myfembree (relugolix/estradiol/norethindrone acetate) ☐ Yes ☐ No

If **yes**, provide medical justification for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

Note: Chart documentation will need to be provided for questions indicated with asterisk

PA requirements for ORIAHNN (elagolix/estradiol/norethindrone acetate):

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Diagnosis of menorrhagia associated with uterine leiomyomas (fibroids) in premenopausal females ☐ Yes ☐ No

3. Negative pregnancy test in the past 30 days* ☐ Yes ☐ No

4. Laboratory tests confirming no hepatic disease in the past 30 days* ☐ Yes ☐ No

5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
   - Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)
   - Current diagnosis of, risk factors for, or previous history of thromboembolic disorders or vascular events
   - Current diagnosis or history of breast cancer or other hormone-sensitive malignancies OR increased risk factors for hormone-sensitive malignancies
   - Diagnosis of osteoporosis
   - Undiagnosed abnormal uterine bleeding

If **no**, please specify contraindication and medical justification for use:

_____

_____

Prescriber Signature: _____

6. Requested dose is 2 capsules (1 x 300/1/0.5 mg; 1 x 300 mg) per day ☐ Yes ☐ No

If **no**, please explain_____

7. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) ☐ Yes ☐ No

If **no**, please provide medical justification:

_____

_____

8. Member will not be exceeding 24 months of therapy per lifetime with elagolix/estradiol/norethindrone acetate therapy ☐ Yes ☐ No

If **yes**, provide medical justification for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

Note: Chart documentation will need to be provided for questions indicated with asterisk

PA requirements for ORILISSA (elagolix):

1. Member is 18 years of age or older ☐ Yes ☐ No

2. Select one of the following diagnoses:

☐ Moderate to severe pain associated with endometriosis with co-existing endometriosis-related dyspareunia AND dose does not exceed 400 mg daily (6-month approval maximum)

☐ Moderate to severe pain associated with endometriosis AND requested dose does not exceed 150 mg daily (1 year approval)

3. Negative pregnancy test in the past 30 days* ☐ Yes ☐ No

4. Laboratory tests confirming no hepatic disease worse than Child-Pugh class B in the past 30 days*
   - Please indicate Child-Pugh classification if applicable:
     ☐ Child-Pugh class A ☐ Child-Pugh class B ☐ N/A
     Note: members with Child-Pugh class B will be limited to 150 mg daily dose for a maximum of 6 months irrespective of indication

5. Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
   - Diagnosis of osteoporosis
   - Concurrent use of organic anion transporting polypeptide (OATP)1B1 inhibitors that are known or expected to significantly increase elagolix plasma concentrations (e.g., cyclosporine, gemfibrozil)

If **no**, please specify contraindication and medical justification for use:

_____

_____

Prescriber Signature: _____

6. Previous trial and failure of hormonal contraceptives/therapy (oral tablets, vaginal ring, patch, and intrauterine contraception) **AND** NSAID therapy ☐ Yes ☐ No

If **no**, please provide medical justification:

_____

_____

7. Member will not be exceeding 24 months of therapy per lifetime with elagolix ☐ Yes ☐ No

If **yes**, provide medical justification for continued use beyond 24 months and date range or number of months member has received therapy thus far:

_____

_____

Note: Chart documentation will need to be provided for questions indicated with asterisk