health information designs

Orilissa
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Orilissa to meet the following prior authorization criteria:

- Patient must have an FDA-approved indication for use and be of the FDA approved age for use
- Documented pain scores must be attached (updated pain scores must be attached to renewals)
- Patient must not have osteoporosis or severe liver disease (Child-Pugh Class C).
- Patient must have failed trials of the following (A and B):
  - A 3-cycle trial of mefenamic acid (or similar fenamate Non-Steroidal Anti-Inflammatory agent (NSAIDs))
  - A 3-cycle trial of twoan oral estrogen-progestin or progestin contraceptives

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Qualifications for coverage:

Has the patient had a negative pregnancy test and will use a non-combination hormone birth control method must be used throughout treatment? □ YES □NO

Does the patient have osteoporosis or severe liver disease (Child-Pugh Class C)? □ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #