



PHARMACY COVERAGE GUIDELINES  
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 9/20/18  
LAST REVIEW DATE: 9/20/18  
LAST CRITERIA REVISION DATE:  
ARCHIVE DATE:

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## ORILISSA™ (elagolix) oral tablet

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Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as “Description” defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as “Criteria” defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy).

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com). **Incomplete forms or forms without the chart notes will be returned.**

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## ORILISSA™ (elagolix) oral tablet (cont.)

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### Criteria:

- **Criteria for initial therapy:** Orilissa (elagolix) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a Gynecologist
  2. Individual is a woman 18 years of age or older
  3. A confirmed diagnosis of moderate to severe pain associated with endometriosis
  4. Individual has failure, contraindication or intolerance to **ALL** the following preferred step therapy agents:
    - **Non-steroidal anti-inflammatory agent** such as ibuprofen, indomethacin, naproxen, meloxicam, and others
    - Oral estrogen-progestin **contraceptive** or depot medroxyprogesterone or norethindrone acetate
  5. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
    - Pregnancy test in a woman of child bearing potential
    - Liver function tests
    - Bone mineral density in a woman with risk factors for bone loss or risk factors for osteoporosis
  6. There are **NO** contraindications.
    - Contraindications include:
      - Pregnancy
      - Known osteoporosis
      - Severe hepatic impairment (Child-Pugh Class C)
      - Strong organic anion transporting polypeptide (OATP) 1B1 inhibitors (i.e. cyclosporine, gemfibrozil)

### Approval duration:

24 months for patients with no coexisting conditions using 150 mg once daily  
6 months for patients with moderate hepatic impairment (Child-Pugh Class B) using 150 mg once daily  
6 months for patients with dyspareunia using 200 mg twice daily

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### Description:

Orilissa (elagolix) is an oral gonadotropin-releasing hormone (GnRH) receptor antagonist that suppresses luteinizing hormone (LH) and follicle-stimulating hormone (FSH), leading to decreased blood concentrations of the ovarian sex hormones, estradiol and progesterone. It is indicated for the management of moderate to severe pain associated with endometriosis. GnRH regulates the anterior pituitary gland synthesis and secretion of FSH and LH.

Endometriosis is defined as endometrial glands and stroma that occur outside the uterine cavity. The lesions are usually located in the pelvis but can occur at other sites including the bowel, diaphragm, and pleural cavity.

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## **ORILISSA™ (elagolix) oral tablet (cont.)**

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Endometriosis is an estrogen-dependent, benign, inflammatory disease that can affect a women during their premenarcheal, reproductive, and postmenopausal hormonal stages. Ectopic endometrial tissue and inflammation may cause dysmenorrhea, dyspareunia, chronic pelvic pain, pelvic tenderness, pelvic induration, infertility and/or an ovarian mass. Less common symptoms include bowel and bladder dysfunction (e.g., dyschezia and dysuria), abnormal uterine bleeding, low back pain, or chronic fatigue. For some, the disease is asymptomatic and is an incidental finding at the time of surgery or imaging done for other indications.

The safety and efficacy of Orilissa were demonstrated in two controlled studies in premenopausal women with moderate to severe endometriosis pain. Patients received either Orilissa or placebo. The primary endpoints were the proportion of patients whose dysmenorrhea responded to treatment at month 3 and the proportion of patients whose non-menstrual pelvic pain responded to treatment at month 3. A higher proportion of women treated with Orilissa were responders for dysmenorrhea and non-menstrual pelvic pain.

A progestin, danazol, extended-cycle combined oral contraceptive, nonsteroidal anti-inflammatory drug (NSAIDs), or GnRH agonist can be used for the initial treatment of pain in women with suspected endometriosis. In women with a history of endometriosis who wish to preserve their fertility, NSAIDs or combined oral contraceptive can be used to treat recurrent pain. Oral or depot medroxyprogesterone acetate is also an effective treatment option. If none of these therapies are successful, a progestin, GnRH agonist, or androgen may be used. If treatment with a GnRH agonist is successful, the use of an add-back regimen can reduce or eliminate bone mineral loss and provide symptomatic relief without reduction in pain.

Add-back therapy refers to the addition of hormone replacement therapy to GnRH agonists, in order to avoid adverse effects that are caused by GnRH agonist-induced hormone suppression. Evidence suggests that add-back therapy is more effective for symptomatic relief than use of a GnRH agonist alone, both immediately after treatment and at 6 months. Add-back therapy increases estrogen levels, but does not reduce the efficacy of GnRH agonists for treating dysmenorrhea and dyspareunia. Add-back regimens have been used in women undergoing long-term therapy; they may include a progestin alone, low dose progestin, progestin plus bisphosphonate, or estrogen.

Lupron Depot 3.75 mg monthly and 11.25 mg every 3 month IM injections are indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions. Lupron Depot monthly with norethindrone acetate 5 mg daily is also indicated for initial management of endometriosis and for management of recurrence of symptoms.

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### **Resources:**

Orilissa. Package Insert. Revised by manufacturer 7/30/18. Accessed 8/23/18.

UpToDate: Endometriosis: Pathogenesis, clinical features, and diagnosis. Current through Apr 2018. [https://www-uptodate-com.mwu.idm.oclc.org/contents/endometriosis-pathogenesis-clinical-features-and-diagnosis?search=endometriosis&source=search\\_result&selectedTitle=1~150&usage\\_type=default&display\\_rank=1](https://www-uptodate-com.mwu.idm.oclc.org/contents/endometriosis-pathogenesis-clinical-features-and-diagnosis?search=endometriosis&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1)



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UpToDate: Endometriosis: Treatment of pelvic pain. Current through Apr 2018. [https://www.uptodate-com.mwu.idm.oclc.org/contents/endometriosis-treatment-of-pelvic-pain?search=endometriosis&source=search\\_result&selectedTitle=3~150&usage\\_type=default&display\\_rank=3](https://www.uptodate-com.mwu.idm.oclc.org/contents/endometriosis-treatment-of-pelvic-pain?search=endometriosis&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3)

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com. Call 866-325-1794 to check the status of a request. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

# Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED:** Office notes, labs, and medical testing relevant to the request that show medical justification are required.

## Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

## Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

## Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
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## Requested Medication Information

Medication Name:	Strength:	Dosage Form:	
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

- Check if requesting **brand** only     Check if requesting **generic**
- Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

## Turn-Around Time For Review

- Standard     Urgent. Sign here: \_\_\_\_\_     Exigent (requires prescriber to include a written statement)

## Clinical Information

1. What is the diagnosis? Please specify below.

ICD-10 Code: \_\_\_\_\_ Diagnosis Description: \_\_\_\_\_

2.  Yes  No Was this medication started on a recent hospital discharge or emergency room visit?

3.  Yes  No There is absence of ALL contraindications.

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.

Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

# Pharmacy Prior Authorization Request Form

**6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.**  
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Prescribing Provider's Signature:	Date:
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**Please note:** Some medications may require completion of a drug-specific request form.

**Incomplete forms or forms without the chart notes will be returned.**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.