



Nevada Medicaid – Molina Healthcare

OriaHnn® (elagolix, estradiol and norethindrone)

Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina 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 requesting brand <input type="checkbox"/> Check if request is for initial therapy <input type="checkbox"/> Check if request is for recertification of therapy		Directions for Use:	

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____

Drug-Specific Information (required)
<input type="checkbox"/> The recipient has documented history of inadequate response following a trial of a combination (estrogen/progesterone) oral contraceptive, progestins, or intrauterine contraception for at least three months. <input type="checkbox"/> The recipient has a documented history of intolerance or contraindication to a combination (estrogen/progesterone) oral contraceptive, progestins, or intrauterine contraception. <input type="checkbox"/> The recipient has had surgical ablation to prevent recurrence.
Reauthorization: <input type="checkbox"/> The recipient has documented improvement in menstrual bleeding. <input type="checkbox"/> Treatment duration has not exceeded a total of 24 months.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or 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 (833) 685-2103. This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**