



Orilissa Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and fax it to the Prior Authorization of Benefits Center 844-474-3341.

1. Patient information

2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

Orilissa	_____	_____	Specify: _____
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7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

- Yes No Does the patient have a diagnosis of endometriosis in the last 730 days?
- Yes No Does the patient have a diagnosis of osteoporosis in the last 365 days?
- Yes No Does the patient have a diagnosis of severe hepatic impairment (Child-Pugh Class C) in the last 365 days?
- Yes No Does the patient have a diagnosis of moderate hepatic impairment (Child-Pugh Class B) in the last 365 days?

For the Texas Medicaid Preferred Drug List, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs>.

provider.wellpoint.com/tx/

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

9. Physician signature

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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