PRIOR AUTHORIZATION POLICY

POLICY: Gonadotropin-Releasing Hormone Antagonists – Orilissa Prior Authorization Policy
- Orilissa™ (elagolix tablets – AbbVie)

REVIEW DATE: 04/26/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Orilissa, an oral gonadotropin-releasing hormone (GnRH) receptor antagonist, is indicated for the management of moderate to severe pain associated with **endometriosis**.[1] Limitation of Use. Limit the duration of use based on the dose and coexisting condition.

The recommended dosage is 150 mg once daily (QD) for up to 24 months (no coexisting conditions) or 200 mg twice daily (BID) for up to 6 months (in patients with coexisting dyspareunia). In patients with moderate hepatic impairment (Child-Pugh Class B), the recommended dosage is 150 mg QD for up to 6 months and the use of 200 mg BID is not recommended. Orilissa is contraindicated in patients with severe hepatic impairment. Duration of therapy is limited due to the anti-estrogenic effects of the medication which include a decrease in bone mineral density.

Disease Overview

Endometriosis is a condition where the tissues similar to the lining of the uterus (or endometrium) migrate outside of the womb to other body sites.[2,3] The migrated tissues are generally found in the pelvic cavity (e.g., peritoneum, uterosacral ligaments, rectal-vaginal septum, or any spaces between the bladder, uterus, vagina, and rectum) and can attach to any of the female reproductive organs (e.g., ovaries,

fallopian tubes). The migrated tissue is less commonly found outside the pelvic cavity or on the intestines, colon, appendix or rectum. Endometriosis impacts up to 10% of patients of reproductive age in the US.[3]

Guidelines

According to the American College of Obstetricians and Gynecologists practice bulletin on the management of endometriosis (2010, reaffirmed 2018), after an appropriate pretreatment evaluation (to exclude other causes of chronic pelvic pain) and failure of initial treatment with oral contraceptives and nonsteroidal anti-inflammatory drugs (NSAIDs), empiric therapy with a 3-month course of a GnRH agonist is appropriate.[2]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Orilissa. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

- **Orilissa™ (elagolix tablets – AbbVie)**

is(are) covered as medically necessary when the following criteria is(are) met for fda-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Endometriosis.** Approve for 6 months if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve if the patient has tried ONE of the following, unless contraindicated (i or ii):
     Note: An exception to the requirement for a trial of the below therapies can be made if the patient had previously used a gonadotropin-releasing hormone agonist (e.g., Lupron Depot [leuprolide depot injection]) or Myfembree (relugolix, estradiol, norethindrone tablets) for endometriosis.
     - **i.** A contraceptive (e.g., combination oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena {levonorgestrel intrauterine system}, Liletta {levonorgestrel intrauterine system}], a depo-medroxyprogesterone injection); OR
     - **ii.** An oral progesterone (e.g., norethindrone tablets); OR
   - **B)** Patient is Currently Receiving Orilissa. Approve.

CONDITIONS NOT COVERED

- **Orilissa™ (elagolix tablets – AbbVie)**

is(are) considered experimental, investigational or unproven for ANY other use(s).

REFERENCES

1. Orilissa™ tablets [prescribing information]. North Chicago, IL: AbbVie; February 2021.
2. Endometriosis. Endometriosis Foundation of America. Available at: https://www.endofound.org/endometriosis. Accessed on April 13, 2023.
3. Global Forum. Endometriosis.org. Available at: http://endometriosis.org/endometriosis/. Accessed on April 13, 2023.
4. Management of Endometriosis. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrican-Gynecologists. Number 114, July 2010. (Reaffirmed 2018) *Obstetrics & Gynecology.* 2010;116(1):223-236.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual revision	No criteria changes.	4/13/2022
Annual revision	**Automation:** Added Myfembree **Endometriosis:** Added Myfembree to the Note.	4/26/2023

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