Effective Date: 01/01/2019
Reviewed: 2/2019, 5/2020, 4/2020, 3/2022, 3/3023, 3/2024, 3/2025, 3/2026 Scope: Medicaid

ORILISSA (elagolix)

POLICY

I. CRITERIA FOR APPROVAL

An authorization may be granted when all the following criteria are met:

A. Orilissa is being used for Endometriosis-related pain that is moderate to severe
B. Documentation that the member tried and failed or has a contraindication to two of the following:
    a. Norethindrone 5mg Tablets, Danazol, Zoladex injection
C. Member does not have Severe Hepatic Impairment (Child-Pugh Class C) or moderate Hepatic Impairment (Child-Pugh Class B) at a dose greater than Orilissa 150mg daily
D. If the member has been previously received treatment with an elagolix-containing product (e.g., Oriahnn, Orlissa) or a relugolix-containing product (e.g. Myfembree) the patient has not already received ANY of the following: greater than 24 cumulative months of treatment with elagolix-containing products (e.g., Oriahnn, Orlissa) and/or relugolix-containing products (e.g. Myfembree), greater than six months of treatment with Orilissa 200 milligrams twice a day

II. QUANTITY LIMIT AND COVERAGE DURATION

Orilissa 200mg twice daily with Dyspareunia – 6 months (max duration of therapy)
Orilissa 150mg daily – 24 months (max duration of therapy)
Orilissa 150mg daily with Moderate Hepatic Impairment (Child-Pugh Class B) – 6 months (max duration of therapy)

III. REFERENCES

1. Orilissa [package insert]. North Chicago, IL: AbbVie Inc.; December 2025. Accessed March 2026.

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