Effective Date: 12/01/2020
Reviewed: 9/2020, 4/2021, 2/2022, 3/2023, 3/2024, 3/2025, 3/2026 Scope: Medicaid

Oriahnn (elagolix, estradiol and norethindrone)
Myfembree (relugolix, estradiol and norethindrone)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 6 months may be granted when all the following criteria are met:

A. Member is 18 years of age and older, **AND**
B. Prescribed by or in consultation with a obstetrics/gynecologist (OB/GYN) or reproductive endocrinologist, **AND**
C. Member has no history of osteoporosis or a bone mineral density T score of -1.5 or less at the lumbar spine, total hip or femoral neck, **AND**
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 or equal to 24 cumulative months of treatment with elagolix-containing products (e.g., Oriahnn, Orlissa) and/or relugolix-containing products (e.g. Myfembree), OR greater than or equal to six months of treatment with Orilissa 200 milligrams twice a day

Uterine Fibroids

A. The member has a documented diagnosis of heavy menstrual bleeding associated with uterine fibroids, **AND**
B. Documentation that member is premenopausal, **AND**
C. Member has tried and failed OR had an intolerance or contraindication to at least three formulary alternatives (i.e., tranexamic acid, norethindrone, NuvaRing, etc.), **AND**
D. Member has no history of pelvic inflammatory disease and/or persistent or complex ovarian cysts if they are requesting Oriahnn;**OR**

Pain Associated with Endometriosis

A. Member has diagnosis of moderate to severe pain associated with endometriosis
B. Documentation that member is premenopausal, AND
C. Member has tried and failed OR had an intolerance, or contraindication after a three-month trial of two analgesics (e.g., ibuprofen, meloxicam, naproxen); AND
D. Member has tried and failed OR had an intolerance, or contraindication after a three-month trial to one of the following: hormonal contraceptives or Progestins(e.g., norethindrone)

II. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for all members who meet all initial criteria and who have documentation of a positive clinical response after at least 6 months of therapy with Oriahnn or Myfembree as evidenced by a decrease in heavy menstrual bleeding and/or pain associated with endometriosis and improvement in overall signs and symptoms of the condition.

III. QUANTITY LIMIT

- Oriahnn: 56 tablets per 28 days
- Myfembree: 28 tablets per 28 days

IV. COVERAGE DURATION

- Maximum of 24 months of therapy

V. REFERENCES

1. Oriahnn [package insert]. North Chicago, IL: AbbVie Inc.; December 2025. Accessed March 2026.
2. MyFembree [package insert]. Brisbane, CA: Myovant Sciences, Inc.; December 2025.