PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

# ADDYI PRIOR AUTHORIZATION FORM

## PATIENT INFORMATION

| Subscriber ID Number | | Group Number | |
|---|---|---|---|
| Patient Name | Patient Telephone Number | | Date of Birth |
| Patient Address | City | State | Zip Code |

## PRESCRIBER INFORMATION

| Physician Name | Phone | | Fax |
|---|---|---|---|
| Physician Address | City | State | Zip Code |
| Suite / Building | Physician Signature | | Date |

## MEDICATION INFORMATION

| Diagnosis: | |
|---|---|
| Quantity: | Day Supply: |

## CLINICAL CRITERIA

1. Is the patient a premenopausal female?
   ☐ Yes ☐ No
2. Does the patient have a current issue with alcohol or substance abuse?
   ☐ Yes ☐ No
3. Has the patient been educated on Addyi administration including the potential adverse effects of alcohol consumption with Addyi?
   ☐ Yes ☐ No
4. Does the patient have a diagnosis of HSDD (hypoactive sexual desire disorder)?
   ☐ Yes ☐ No

   If **YES**:

   a. Is the patient's diagnosis of HSDD related to a co-existing medical or psychiatric condition, substance abuse, or relationship issue?
      ☐ Yes ☐ No

   b. Has the patient experienced therapeutic failure of behavioral therapy for HSDD?
      ☐ Yes ☐ No

   c. Is the patient currently enrolled in behavioral therapy for HSDD?
      ☐ Yes ☐ No

   d. Is the patient a candidate for behavioral therapy for HSDD?
      ☐ Yes ☐ No
5. Is this a request for reauthorization?
   ☐ Yes ☐ No

   If **YES**:

   a. Is the patient tolerating therapy with Addyi?
      ☐ Yes ☐ No

   b. Is the patient experiencing improved sexual desire from baseline?
      ☐ Yes ☐ No

6. Please provide any other medications previously tried and failed for the patient's diagnosis:

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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.

## INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   **NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   **120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222**