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

VYLEESI PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number		Subscriber's Group Number
Patient's Name	Phone	Date of Birth
Address	City / State / Zip Code	

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax
Address	City / State / Zip Code		
Suite / Building	Physician's 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 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, problems with the relationship, or the effects of a medication or drug substance?
      ☐ Yes ☐ No

   b. Is the patient a candidate for behavioral therapy for HSDD?
      ☐ Yes ☐ No

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

   d. Has the patient experienced therapeutic failure of behavioral therapy for HSDD?
      ☐ Yes ☐ No
3. Is this a request for reauthorization?
   ☐ Yes ☐ No

   If **YES**:

   a. Has the patient experienced improved sexual desire from baseline?
      ☐ Yes ☐ No
4. Please provide any other medications previously tried and failed for the patient's diagnosis:

   _____

   _____

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