HIGHMARK WEST VIRGINIA

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. 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
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