FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Addyi® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acquired, generalized hypoactive sexual desire disorder (HSDD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the diagnosis due to a co-existing medical or psychiatric condition? ❑ **Yes** ❑ **No**

Is the diagnosis due to relationship problems? ❑ **Yes** ❑ **No**

Is the diagnosis due to the effects of a medication or other drug substance? ❑ **Yes** ❑ **No**

Is the patient premenopausal? ❑ **Yes** ❑ **No**

Have the symptoms of HSDD persisted for at least 6 months? ❑ **Yes** ❑ **No**

Has the prescriber confirmed that the patient has no known history of alcohol abuse or for a patient with a known history of alcohol abuse, the patient has abstained from alcohol abuse for the past 6 months? ❑ **Yes** ❑ **No**

Has the prescriber confirmed that the patient agrees to abstain from alcohol during therapy? ❑ **Yes** ❑ **No**

Does the patient have hepatic impairment (i.e., Child-Pugh score of 6 points or greater)? ❑ **Yes** ❑ **No**

Will Addyi be used concomitantly with moderate or strong cytochrome P450 3A4 inhibitors (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil, etc.)? ❑ **Yes** ❑ **No**

Reauthorization:

If this request is for reauthorization, answer the following:

Has the patient had a positive clinical response to Addyi therapy? ❑ **Yes** ❑ **No**

Is the patient still premenopausal? ❑ **Yes** ❑ **No**

Does the patient continue to abstain from alcohol use during treatment with Addyi? ❑ **Yes** ❑ **No**

Does the patient have hepatic impairment (i.e., Child-Pugh score of 6 points or greater)? ❑ **Yes** ❑ **No**

Will Addyi be used concomitantly with moderate or strong cytochrome P450 3A4 inhibitors (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil, etc.)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.