



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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
<p><b>Select the diagnosis below:</b></p> <input type="checkbox"/> Acquired, generalized hypoactive sexual desire disorder (HSDD) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<p><b>Clinical information:</b></p> <p>Is the diagnosis due to a co-existing medical or psychiatric condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the diagnosis due to relationship problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the diagnosis due to the effects of a medication or other drug substance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient premenopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have the symptoms of HSDD persisted for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the prescriber confirmed that the patient agrees to abstain from alcohol during therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have hepatic impairment (i.e., Child-Pugh score of 6 points or greater)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Addyi be used concomitantly with moderate or strong cytochrome P450 3A4 inhibitors (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Reauthorization:</b></p> <p><b>If this request is for reauthorization, answer the following:</b></p> <p>Has the patient had a positive clinical response to Addyi therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient still premenopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient continue to abstain from alcohol use during treatment with Addyi? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have hepatic impairment (i.e., Child-Pugh score of 6 points or greater)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Addyi be used concomitantly with moderate or strong cytochrome P450 3A4 inhibitors (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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

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

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