OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Addyi® Prior Authorization Request Form (Page 1 of 2)

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

Patient Information (required)			Provider Information (required)		
Patient 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 requesting **brand**	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)
❑ Female sexual interest/arousal disorder
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Have the symptoms of HSDD or female sexual interest/arousal disorder persisted for at least 6 months? ❑ **Yes** ❑ **No**
Is low sexual desire due to any of the following: A co-existing medical or psychiatric condition, problems within the relationship, or the effects of a medication or other drug substance? ❑ **Yes** ❑ **No**
Is the patient premenopausal? ❑ **Yes** ❑ **No**
Is the prescriber certified/enrolled in the Addyi REMS Program? ❑ **Yes** ❑ **No**
Does the patient have a known history of alcohol abuse? ❑ **Yes** ❑ **No**
For patients with a known history of alcohol abuse, has the patient abstained from alcohol abuse for the past 6 months? ❑ **Yes** ❑ **No**
Will the patient abstain from alcohol use during treatment with Addyi? ❑ **Yes** ❑ **No**
Does the patient have hepatic impairment (i.e., a Child-Pugh score of 6 points or greater)? ❑ **Yes** ❑ **No**
Is the patient concomitantly on a moderate or strong CYP3A4 inhibitor (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil)? ❑ **Yes** ❑ **No**

Prescriber attestation:

Does the prescriber attest to ALL of the following? ❑ **Yes** ❑ **No**

- The potential benefits of Addyi therapy outweigh the risks
- Both the prescriber and patient have completed the Addyi REMS Program Patient-Provider Agreement Form
- The information provided is true and accurate to the best of their knowledge and they understand that the plan may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to Addyi therapy? ❑ **Yes** ❑ **No**
Does the patient continue to be premenopausal? ❑ **Yes** ❑ **No**
Has the patient continued to abstain from alcohol use during treatment with Addyi? ❑ **Yes** ❑ **No**
Does the patient have hepatic impairment (i.e., a Child-Pugh score of 6 points or greater)? ❑ **Yes** ❑ **No**
Is the patient concomitantly on a moderate or strong CYP3A4 inhibitor (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil)? ❑ **Yes** ❑ **No**

Addyi® Prior Authorization Request Form (Page 2 of 2)

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Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.