OPTUMRx

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health

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

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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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Prescribers must be certified in the Addyi REMs program. Prescribers must review and complete the patient-provider agreement form with every patient prior to prescribing Addyi.

Select the diagnosis below:

❑ Hypoactive sexual desire disorder (HSDD) with symptoms (low sexual desire that causes marked distress or interpersonal difficulty) that have persisted for at least 6 months

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

Clinical information:

Is the patient pre-menopausal? ❑ **Yes** ❑ **No**

Is the patient's HSDD related to any other medical or psychiatric condition, substance abuse or relationship issue? ❑ **Yes** ❑ **No**

Does the patient have history of alcohol abuse? ❑ **Yes** ❑ **No**

Has the patient abstained from alcohol for the past 6 months AND will abstain from alcohol while on Addyi therapy? ❑ **Yes** ❑ **No**

Alcohol screening completed at the time of prescribing MUST be attached

Does the patient have hepatic impairment (Child-Pugh score of ≥ 6 points)? ❑ **Yes** ❑ **No**

Is the patient using moderate or strong CYP3A4 inhibitors concomitantly? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient's sexual desire and number of satisfying sexual events increased from baseline? ❑ **Yes** ❑ **No**

Chart notes must be submitted documenting improvement in number of satisfying sexual events and symptoms

Is the patient pre-menopausal? ❑ **Yes** ❑ **No**

Will the patient abstain from alcohol while on Addyi therapy? ❑ **Yes** ❑ **No**

Alcohol screening completed at the time of prescribing MUST be attached

Does the patient have hepatic impairment (Child-Pugh score of ≥ 6 points)? ❑ **Yes** ❑ **No**

Is the patient using moderate or strong CYP3A4 inhibitors concomitantly? ❑ **Yes** ❑ **No**

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: ______________________________ **Date:** ______________________________

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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.
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.

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