AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: **Vyleesi™** (bremelanotide acetate)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ______________________________

Member AvMed #: ______________________ **Date of Birth:** ____________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ **Date:** ____________

Office Contact Name: ______________________________

Phone Number: ______________________ **Fax Number:** ______________________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ____________

Diagnosis: ______________________ **ICD Code:** ______________________

Weight: ______________________ **Date:** ______________________

Quantity Limit: 8 doses (2.4 mL) per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.
Authorization Criteria:

- ❑ Member is pre-menopausal
- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of Hypoactive Sexual Desire Disorder (HSDD) with symptoms (e.g., low sexual desire that causes marked distress or interpersonal difficulty) that have persisted for at least 6 months
- ❑ Member's HSDD is **NOT** related to any other medical or psychiatric condition, substance abuse or relationship issue

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- ❑ Member has had an unsuccessful 8-week trial of Addyi® **(*requires prior authorization: See www.avmed.org/ for prior authorization form; chart notes must be submitted to document Addyi® failure)**
- ❑ The prescribing physician has determined the average pre-treatment number of satisfying sexual events for the patient over a specific time frame (example: two satisfying sexual events over 1 month) in order to evaluate Vyleesi treatment efficacy after therapy initiation
- ❑ Member does **NOT** have uncontrolled hypertension or known cardiovascular disease
- ❑ Member will **NOT** be using more than 8 doses per month or more than one dose within a 24-hour time-frame

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****