HIGHMARK | HIGHMARK

Medication Prior Authorization Form
Fax to 1-866-240-8123

Addyi

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply ☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis and/or ICD-10 code(s)			

Clinical Information:

1. Does the member have a current issue with alcohol or substance abuse?	Yes	No
2. Has the member been educated on Addyi administration including the potential adverse effects of alcohol consumption with Addyi?	Yes	No
3. Does the member have a diagnosis of HSDD (hypoactive sexual desire disorder)?	Yes	No
If the member has HSDD (hypoactive sexual desire disorder):		
3a. Is the member's diagnosis of HSDD related to a co-existing medical or psychiatric condition, substance abuse, or relationship issue?	Yes	No
3b. Is the member a candidate for behavioral therapy for HSDD?	Yes	No
3c. Is the member currently enrolled in behavioral therapy for HSDD?	Yes	No
3d. Has the member experienced therapeutic failure of behavioral therapy for HSDD?	Yes	No

Reauthorization:

If this is a request for reauthorization, please answer the following:		
1. Is the member tolerating therapy with Addyi?	Yes	No
2. Is the member experiencing improved sexual desire from baseline while on therapy with Addyi?	Yes	No

Medication History:

Please provide any other medications that the member has tried and failed:

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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