



VYLEESI PRIOR AUTHORIZATION FORM
PATIENT INFORMATION

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

PRESCRIBER INFORMATION

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

MEDICATION INFORMATION

Diagnosis:	
Quantity:	Day Supply:

CLINICAL CRITERIA

1. Is the patient a premenopausal female?
 Yes No

2. Does the patient have a diagnosis of HSDD (hypoactive sexual desire disorder)?
 Yes No
If YES:
 - a. Is the patient's diagnosis of HSDD related to a co-existing medical or psychiatric condition, problems with the relationship, or the effects of a medication or drug substance?
 Yes No
 - b. Is the patient a candidate for behavioral therapy for HSDD?
 Yes No
 - c. Is the patient currently enrolled in behavioral therapy for HSDD?
 Yes No
 - d. Has the patient experienced therapeutic failure of behavioral therapy for HSDD?
 Yes No

3. Is this a request for reauthorization?
 Yes No
If YES:
 - a. Has the patient experienced improved sexual desire from baseline?
 Yes No

4. Please provide any other medications previously tried and failed for the patient's diagnosis:

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**

Or mail the form to: **Clinical Services,**
 120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222