

# HYPOLACTIVE SEXUAL DESIRE DISORDER (HSDD) PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Acquired, generalized hypoactive sexual desire disorder (HSDD) <input type="checkbox"/> Female sexual interest/arousal disorder (FSIAD) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Will the patient be using the requested agent in combination with another target agent in this program (Addyi, Vyleesi) for the requested indication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is the requested agent medically appropriate for the patient's sex? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____	
5. Is the patient premenopausal?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Has the patient tried and had an inadequate response to other treatment modalities (e.g., education, modification factors thought to be contributing to HSDD/FSIAD, and sex therapy)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____ _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For Acquired, generalized hypoactive sexual desire disorder (HSDD) or Female sexual interest/arousal disorder (FSIAD) requests:**

8. Is the patient's diagnosis characterized by low sexual desire that causes marked distress or interpersonal difficulty? .....  Yes  No
9. Have the patient's symptoms of low sexual desire been present for at least 6 months?.....  Yes  No
10. Is the patient's HSDD/FSIAD due to ANY of the following? .....  Yes  No
- If yes, please select ALL that apply:
- A co-existing medical or psychiatric condition
  - The effects of a medication or other drug substance
  - Problems within the relationship

**For renewal requests:**

11. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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