

TRICARE Prior Authorization Request Form for
flibanserin (**Addyi**)



JOHNS HOPKINS
M E D I C I N E
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HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial approval expires after 3 months. For renewal of therapy an initial TRICARE prior authorization approval is required.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Addyi.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 11	<input type="checkbox"/> No Proceed to question 2
2. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the patient a premenopausal female?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a documented diagnosis of hypo-sexual desire disorder (HSDD)? Note: Non-FDA approved uses are NOT approved.	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the HSDD due to a co-existing medical or psychiatric condition, problems within the relationship, or effects of a medication or other drug substance?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 6
6. Does the patient currently use alcohol?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No Proceed to question 8

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7. Has the patient been counseled to wait 2 hours after consuming 1 or 2 standard alcoholic drinks before taking Addyi at bedtime or to skip their Addyi dose if they have consumed 3 or more standard alcoholic drinks that evening? After taking Addyi, do not use alcohol until the following day.	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Does the patient have hepatic impairment (Child-Pugh score at least 6)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 9
9. Is the patient receiving concomitant therapy with a moderate or strong CYP3A4 inhibitor (for example, ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 10
10. Has the patient been informed that other treatment options such as cognitive-behavior therapy, sexual therapy, or couples therapy, may provide benefit without risk of side effects?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
11. Does the patient have documented improvement in symptoms without serious side effects?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.
Please sign and date:

_____ Prescriber Signature

_____ Date

[21 August 2020]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: