Prior Authorization Request Form for
bremelanotide injection **(Vyleesi)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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

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

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

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 Vyleesi*	☐ Yes (subject to verification) Proceed to question **10**	☐ No Proceed to question **2**
2. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient a premenopausal woman with a documented diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient's diagnosis characterized by low sexual desire that causes marked distress or interpersonal difficulty?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient's decreased sexual desire caused by any of the following: • **co- existing medical or psychiatric condition** • **problems with the relationship** • **effects of a medication or drug substance**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. 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?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Does the patient have uncontrolled hypertension or known cardiovascular disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **8**
8. Has the patient been counseled on the risks of focal hyperpigmentation (skin discoloration) and severe nausea?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient agree to use effective contraception while taking Vyleesi?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. Has the patient had documented improvements in symptoms without serious side effects?	☐ Yes **Sign and date below**	☐ 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

[19 February 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: