

# AvMed

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested:** Addyi® (flibanserin)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member AvMed #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

**Quantity Limit:** 30 tablets per 30 days

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

### **Authorization Criteria**

- Member is between 18 and less than 65 years of age
- Member has a diagnosis of Hypoactive Sexual Desire Disorder (HSDD) with symptoms (e.g., low sexual desire that causes marked distress or interpersonal difficulty) that have persisted for at least 6 months
- Member's HSDD is **NOT** related to any other medical or psychiatric condition, substance abuse or relationship issue
- Member does **NOT** have any degree of hepatic impairment

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- ❑ Member is **NOT** using moderate or strong CYP3A4 inhibitors concomitantly (e.g., ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil)
- ❑ Provider attests to having counseled the member regarding the interaction with alcohol and Addyi, and the increased risk of hypotension and syncope

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****