CAREFIRST
Vyleesi

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Vyleesi.

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Vyleesi (bremelanotide)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the patient premenopausal?	**Y** ☐	**N** ☐
2.	Does the patient have a diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD)?	**Y** ☐	**N** ☐
3.	Is the hypoactive sexual desire disorder (HSDD) caused by ANY of the following: A) A co-existing medical or psychiatric condition, B) Problems with the relationship, C) The effects of a medication or drug substance?	**Y** ☐	**N** ☐
4.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
5.	Has the patient received at least an 8-week supply of the requested drug as a paid claim through a pharmacy benefit (excluding the use of samples or vouchers/coupons)?	**Y** ☐	**N** ☐
6.	Has the patient experienced an improvement in the symptoms of hypoactive sexual desire disorder (HSDD) since starting this therapy?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 8 autoinjectors per month?	**Y** ☐	**N** ☐
8.	Has the diagnosis been appropriately documented (i.e., evaluated by a complete clinical assessment, using Diagnostic and Statistical Manual of Mental Disorders (DSM) and interviews/questionnaires)?	**Y** ☐	**N** ☐
9.	Does the patient require MORE than the plan allowance of 8 autoinjectors per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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