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.	Has the patient received at least an 8 week supply of this medication as a paid claim through a pharmacy or medical benefit (excluding the use of samples or vouchers/coupons)?	**Y** ☐	**N** ☐
3.	Has the patient reported an improvement in the symptoms of hypoactive sexual desire disorder (HSDD)?	**Y** ☐	**N** ☐
4.	Is the hypoactive sexual desire disorder (HSDD) caused by any of the following: A) co-existing medical or psychiatric condition, B) problems within the relationship, C) effects of a medication or other drug substance?	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance of 8 autoinjectors per month?	**Y** ☐	**N** ☐
6.	Does the patient have the diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD)?	**Y** ☐	**N** ☐
7.	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** ☐
8.	Is the hypoactive sexual desire disorder (HSDD) caused by any of the following: A) co-existing medical or psychiatric condition, B) problems within the relationship, C) effects of a medication or other drug substance?	**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