US Family Health Plan
Prior Authorization Request Form for
bremelanotide injection (**Vyleesi**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial therapy approves for 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/USFHP 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**

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