US Family Health Plan
Prior Authorization Request Form for
flibanserin **(Addyi)**

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 855-273-5735

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 approval expires after 3 months. For renewal of therapy an initial USFHP 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 USFHP/ TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP/ TRICARE approved PA for Addyi.*	☐ Yes (subject to verification) Proceed to question **11**	☐ 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 female?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a documented diagnosis of hypo-sexual desire disorder (HSDD)? Note: Non-FDA approved uses are NOT approved.	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the HSDD due to a co-existing medical or psychiatric condition, problems within the relationship, or effects of a medication or other drug substance?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Does the patient currently use alcohol?	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**

7. Has the patient been counseled to wait 2 hours after consuming 1 or 2 standard alcoholic drinks before taking Addyi at bedtime or to skip their Addyi dose if they have consumed 3 or more standard alcoholic drinks that evening? After taking Addyi, do not use alcohol until the following day.	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have hepatic impairment (Child-Pugh score at least 6)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient receiving concomitant therapy with a moderate or strong CYP3A4 inhibitor (for example, ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. 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 **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Does the patient have documented improvement 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