Vyleesi® Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

VYL23-01

PATIENT INFORMATION

Last Name	First Name	Date of Birth ____ /____ / ____	
Address	City	State	Zip
Email	Home Phone	Work Phone	Cell Phone

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes*

☐ Patient New to Therapy / Naïve ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date ____ /____ / ____

Height _____ in Weight _____ lb. Date ____ /____ / ____

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Concomitant Medications (please list name and dose)

Please indicate if any of the following co-existing circumstances were identified at the time of diagnosis:

☐ Problem(s) with relationships
☐ Psychiatric or medical condition(s)
☐ Other medication(s) or drug substance(s)
☐ Other, please explain: _____

Indication Demographics:

☐ Patient is 18 years or older
☐ Patient is premenopausal
☐ Patient has experienced HSDD for more than 6 months
☐ Patient has experienced HSDD for less than 6 months

Does patient have cardiac disease or uncontrolled hypertension? ☐ Yes ☐ No

ICD-10 Code ☐ F52.0 Female hypoactive sexual desire ☐ Other: _____
☐ F52.2 Sexual arousal disorders

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refill
☐ **VYLEESI® (bremelanotide)**	1.75 mg/0.3 mL	Inject one pre-filled syringe subcutaneously in abdomen or thigh at least 45 minutes before anticipated sexual activity as needed.	☐ 4 single-dose autoinjectors ☐ 8 single-dose autoinjectors ☐ _____	☐ 1-year ☐ _____
☐ **Ondansetron**	8 mg	Take one tablet every 12 hours as needed for nausea	☐ 30 tablets ☐ _____	☐ 1-year ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic

Date Shipment Needed By: ____ /____ / ____