carolina complete health

Pharmacy Prior Approval Request for Vivjoa

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____

3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: ____

11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

☐ Other _____

Clinical Information

Requests for Vivjoa:

1. Does the beneficiary have a diagnosis of recurrent vulvovaginal candidiasis with ≥3 laboratory confirmed episodes of vulvovaginal candidiasis (VVC) in a 12-month period? ☐ **Yes** ☐ **No**

2. Is the beneficiary a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)? ☐ **Yes** ☐ **No**

3. Does the beneficiary have a hypersensitivity to any component of the product? ☐ **Yes** ☐ **No**

4. Is the beneficiary pregnant? ☐ **Yes** ☐ **No**

5. Is the beneficiary lactating? ☐ **Yes** ☐ **No**

6. Has the beneficiary tried and failed or has a contraindication or intolerance to monthly maintenance antifungal therapy with oral fluconazole x 6 months? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date:_____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.