



**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Vivjoa**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. 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.

Fax this form to (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318