AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Vivjoa

Beneficiary Information

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

Prescriber Information

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406