United Healthcare Community Plan

**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 1-866-940-7328
03.01.2024

Pharmacy PA Call Center: 1-855-258-1593