

# SENTARA COMMUNITY PLAN (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested:** Vivjoa™ (oteseconazole)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

### **Recommended Dosage:**

**Vulvovaginal candidiasis, recurrent:**

- **For Vivjoa only regimen: Oral:**
  - Day 1: 600 mg, as a single dose
  - Day 2: 450 mg, as a single dose
  - Beginning on Day 14: Administer 150 mg once a week (every 7 days) for 11 weeks (Weeks 2 through 12)
- **For Vivjoa and fluconazole regimen: Oral:**
  - Days 1 to 7: **Fluconazole** 150 mg, as a single dose, on days 1, 4, and 7
  - Days 14 to 20: **Vivjoa** 150 mg once daily for 7 days
  - Beginning on day 28: **Vivjoa** 150 mg once weekly for 11 weeks (Weeks 4 through 14)

**Quantity Limits:** 18 capsules per treatment course

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**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Authorization: Date of Service**

**All of the following criteria must be met:**

- Member is  $\geq 10$  years of age
- Documentation member has diagnosis of recurrent vulvovaginal candidiasis with  $\geq 3$  episodes of vulvovaginal candidiasis (VVC) in a 12-month period
- Member is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)
- Member has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole.

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****