Trillium Health Resources
Pharmacy Prior Approval Request for

# Vivjoa

## Member Information

1. Last Name: _______________________________________ 2. First Name: ____________________________________
3. Trillium ID #: _____________________________ 4. Date of Birth: __________________ 5. Gender: _______________

## Prescriber Information

1. Prescriber Name: _____________________________________________ 2. NPI #: ______________________________
3. Requestor Name (Nurse/Office Staff): __________________________________________________________________
4. Mailing Address: __________________________________________ City: __________________ State: _____ Zip: _____
5. Phone #: ____________________________________ Ext. ________ Fax #: _____________________________________

## Drug Information

1. Drug Name:___________________ 2. Strength: __________________ 3. Quantity per 30 Days _________________
4. Length of Therapy (in days): ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other_________________

## Clinical Information

**Requests for Vivjoa:**

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

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

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

6. Has the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277**