AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **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 84 days

(Continued on next page)

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.

All of the following criteria must be met:

- ❑ Member is ≥ 18 years of age
- ❑ Member is postmenopausal or has permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)
- ❑ Member is currently experiencing signs and symptoms consistent with an acute episode of VVC (e.g., vulvovaginal pain, pruritis or irritation, abnormal vaginal discharge), **AND** it is a laboratory confirmed VVC episode **(please include laboratory documentation or medical chart notes to confirm diagnosis (i.e., urinalysis, microscopic examination via 10% KOH, culture))**
- ❑ Member has a history of recurring VVC (RVVC) **(please include past medical history notes recording RVVC, defined as ≥ 3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period)**
- ❑ Member remains symptomatic and culture positive after therapy with fluconazole, completing a 6-month dosing regimen as follows unless intolerant or contraindicated **(please include medical chart/progress notes and laboratory results; pharmacy claims history and chart notes must confirm failure, intolerance or contraindication to therapy)**:
  - ❑ 100, 150 or 200 mg oral dose of fluconazole every third day for a total of 3 doses (days 1, 4 and 7)
  - ❑ Followed by oral fluconazole (100, 150 or 200 mg oral dose) weekly for 6 months as the maintenance regimen

OR

- ❑ Member has previously completed a course of treatment with the Vivjoa within the past 12 months, and meets all the above clinical documentation and diagnosis criteria above **(verified by chart notes or pharmacy paid claims)**

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****