Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

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.