TRICARE Prior Authorization Request Form for
oteseconazole **(Vivjoa)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the medication being prescribed by a gynecologist?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Is the patient post-menopausal?	☐ Yes Proceed to question 4	☐ No Proceed to question 3
3. Is the patient post-menarchal and not of reproductive potential (for example: history of tubal ligation, salpingo-oophorectomy, or hysterectomy)?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Does the patient have recurrent vulvovaginal candidiasis (RVVC)? RVVC is defined as at least 4 acute episodes of symptomatic vulvovaginal candidiasis in a year.	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Is the diagnosis of recurrent vulvovaginal candidiasis (RVVC) confirmed by microscopy, Nucleic Acid Amplification Tests (NAAT) or culture?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Has the patient experienced therapeutic failure, contraindication, or intolerance to a six-month maintenance course of oral fluconazole?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[9 November 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: