

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT VAGINAL ANTIMICROBIALS PRIOR AUTHORIZATION REQUEST FORM



CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date			Non-Urgent □	Urgent □
Note: This form must be completed by the *All sections			will be returned**	
Patient's CareSource #		Date of Birth	/ / /	
Patient's Name		Prescriber's Name		
Prescriber's Indiana License #		Specialty		
Prescriber's NPI #		Office Contact		
Prescriber		Prescriber's Phone #		-
Prescriber address		Date(s) of Service	ce	
		Start Date		
Requested Medication	Strength	Quantity	Directions	for Use
I attest that the information on this form	า is accurate:			
I attest that the information on this forn	n is accurate:			
I attest that the information on this form Physician Signature:			Date:	
			Date:	
Physician Signature:	MME (ibrexafung	erp):		
Physician Signature: PA Requirements for BREXAFEM	MME (ibrexafung	erp):	Date: de:	
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnoses	IME (ibrexafung ses: al candidiasis aginal candidiasis (Diagnosis Cod	de:	— ore episodes of
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos □ Diagnosis of acute vulvovagina □ Diagnosis of recurrent vulvova	MME (ibrexafung ses: al candidiasis aginal candidiasis (n the past year)	Diagnosis Cod must provide docu Diagnosis Cod	de: umentation of three or mo de:	 ore episodes of
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos Diagnosis of acute vulvovagina Diagnosis of recurrent vulvova vulvovaginal candidiasis within	MME (ibrexafung ses: al candidiasis aginal candidiasis (a the past year) age: Provider atte	Diagnosis Cod (must provide docu Diagnosis Cod sts the member is	de: umentation of three or mo de: postmenarchal? □ Yes	 ore episodes of
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos Diagnosis of acute vulvovagina Diagnosis of recurrent vulvova vulvovaginal candidiasis within 2. For members less than 18 years of Provider Printed Name:	MME (ibrexafung ses: al candidiasis aginal candidiasis (a the past year) age: Provider atte	Diagnosis Cod (must provide docu Diagnosis Cod sts the member is	de: umentation of three or mo de: postmenarchal? □ Yes	 ore episodes of
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos Diagnosis of acute vulvovagina Diagnosis of recurrent vulvova vulvovaginal candidiasis within 2. For members less than 18 years of	MME (ibrexafung ses: al candidiasis aginal candidiasis (a the past year) age: Provider atte	Diagnosis Cod (must provide docu Diagnosis Cod sts the member is	de: umentation of three or mo de: postmenarchal? □ Yes	— ore episodes of — □ No
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos Diagnosis of acute vulvovagina Diagnosis of recurrent vulvova vulvovaginal candidiasis within 2. For members less than 18 years of Provider Printed Name: Provider Signature:	MME (ibrexafung ses: al candidiasis aginal candidiasis (a the past year) age: Provider atte	Diagnosis Coo (must provide docu Diagnosis Coo sts the member is	de:umentation of three or mode: postmenarchal? □ Yes attached (if applicable)?	ore episodes of □ No □ Yes □ No
Physician Signature: PA Requirements for BREXAFEM 1. Select one of the following diagnos Diagnosis of acute vulvovagina Diagnosis of recurrent vulvova vulvovaginal candidiasis within 2. For members less than 18 years of Provider Printed Name: Provider Signature: 3. Documentation of a negative pregin	MME (ibrexafung ses: al candidiasis (aginal candidiasis (a the past year) age: Provider atte	Diagnosis Coo (must provide docu Diagnosis Coo sts the member is the past 30 days is	de:umentation of three or mode: postmenarchal? □ Yes attached (if applicable)?	ore episodes of No Yes □ No

1. Diagnosis of recurrent vulvovaginal candidiasis? □ Yes □ No Diagnosis Code:	
Note: Provide documentation of three or more episodes of vulvovaginal candidias member within the past year.	sis experienced by
2. Is the member 18 years of age or older? □Yes □ No	
3. Does the provider attest the member is not considered to be of reproductive potential?	□ Yes □ No
4. Has the member had a trial and failure history of oral fluconazole within the past year?	□ Yes □ No
If no, provide medical rationale supporting use of Vivjoa (otesenconazole) over	oral fluconazole:

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at 1-844-607-2831.