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

**MDwise**
**Fax to: (858) 790-7100**
**c/o MedImpact Healthcare Systems, Inc.**
**Attn: Prior Authorization Department**
**10181 Scripps Gateway Court, San Diego, CA 92131**
**Phone: (800) 788-2949**

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

**Note:** This form must be completed by the prescribing provider.
****All sections must be completed or the request will be returned****

| | |
|---|---|
| Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Prescriber's Signature |
| Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Check box if requesting retro-active PA ☐ | Date(s) of service requested for retro-active eligibility (if applicable): |

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

| Requested Medication | Strength | Dosage Regimen |
|---|---|---|
| | | |

## PA Requirements for BREXAFEMME (ibrexafungerp):

1. One of the following diagnoses:

   ☐ Diagnosis of acute vulvovaginal candidiasis

   ☐ Diagnosis of recurrent vulvovaginal candidiasis (must provide documentation of 3 or more episodes of vulvovaginal candidiasis within the past year)

2. For members less than 18 years of age: provider attests member is postmenarchal ☐ Yes ☐ No

   Provider printed name and signature:_____

3. Documentation of a negative pregnancy test within the past 30 days attached ☐ Yes ☐ No

4. Member has a trial and failure history of oral fluconazole within the past year ☐ Yes ☐ No

   If no, provide medical rationale supporting use of Brexafemme (ibrexafungerp) over oral fluconazole

   _____

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**PA Requirements for VIVJOA (oteseconazole):**

1. Diagnosis of recurrent vulvovaginal candidiasis ☐ Yes ☐ No

   **Note:** provide documentation of 3 or more episodes of vulvovaginal candidiasis experienced by member within the past year

2. Member is 18 years of age or older ☐ Yes ☐ No

3. Provider attests member is not considered to be of reproductive potential ☐ Yes ☐ No

4. Member has a trial and failure history of oral fluconazole within the past year ☐ Yes ☐ No

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