VIVJOA® (oteseconazole) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

VIV26-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date ____ /____ / ____

Allergies ☐ NKDA ☐ Drug Allergies (please list) History of hypersensitivity to azoles ☐ Yes ☐ No

Therapies Tried and Failed (please check name and include dates)

☐ Oral Fluconazole Date ____ /____ / ____
☐ Topical Fluconazole Date ____ /____ / ____
☐ Oral Miconazole Date ____ /____ / ____
☐ Topical or vaginal suppository Miconazole Date ____ /____ / ____
☐ Topical or vaginal suppository Terconazole Date ____ /____ / ____
☐ Boric acid vaginal suppository Date ____ /____ / ____
☐ Topical Clotrimazole Date ____ /____ / ____
☐ Topical Butoconazole Date ____ /____ / ____

Reason for therapeutic failure/therapy not tried

☐ Adverse Reactions (nausea, headache, skin rash, abdominal pain)
☐ Adherence concerns
☐ History of resistance to fluconazole or another antifungal
☐ Interactions with current treatment plan
- CYP3A4 substrates (simvastatin, amlodipine, tacrolimus, alprazolam, oral contraceptives, hydrochlorothiazide)
- QTc prolonging medications (amiodarone, amitriptyline)

☐ Diagnosis of HIV and on antiviral medications
☐ Prolonged QTc interval
☐ Other: _____

Potential drug interactions (check if patient is concurrently being treated with):

☐ Breast Cancer Resistance Protein Substrates (rosuvastatin, methotrexate)
☐ Other:
_____

Indication Demographics

Patient is postmenopausal ☐ Yes ☐ No
Patient is permanently infertile ☐ Yes ☐ No
Episodes of yeast infections in the past 12 months ☐ 1 ☐ 2 ☐ 3 ☐ ≥4

Current Medications (please list name and dose)

ICD-10 Code ☐ B37.32 Recurrent vulvovaginal candidiasis
☐ Other: _____

PRESCRIPTION – *please check all boxes across row*

Medication	Dose	Directions	Quantity/Day Supply	Refills
☐ **VIVJOA®** (oteseconazole)	150 mg	Administer 600 mg on day one, then 450 mg on day two, then beginning on day 14, administer 150 mg once a week (every 7 days) for 11 weeks. Total duration of 12 weeks.	☐ 18 capsule blister package/12 weeks ☐ _____	☐ 0 ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic | Date Shipment Needed By: ____ /____ / ____