



417 20th Street North, Suite 1100
 Birmingham, AL 35203
 Fax Number: (205) 449-2465

COVERAGE DETERMINATION FORM

Please Note Any Incomplete or Illegible Information Will Delay the Review Process

| Patient Information: | | Prescriber Information: | |
|----------------------|--|-------------------------|--|
| Patient Name: | | Physician: | |
| Member ID #: | | Office Phone #: | |
| Date of Birth: | | Office Fax #: | |
| Phone #: | | DEA #: | |
| Address: | | Office Contact: | |

View Commercial Preferred Drug List at: <http://www.vivaemployer.com/Members/Default.aspx>

| Medication and Diagnosis Information: | | | |
|---------------------------------------------------------------------------|---------------|-----------|--|
| Medication: | | Strength: | |
| Route: | Frequency: | Quantity: | |
| Diagnosis: (Please Attach All Office Notes and Labs Supporting Diagnosis) | | | |
| Alternate Drug(s) Previously Tried or Contraindicated: | | | |
| Drug: | Date(s) Used: | Outcome: | |
| Drug: | Date(s) Used: | Outcome: | |

| Rationale for Request: (Required) | |
|-----------------------------------|-------|
| | |
| Prescriber's Signature: | Date: |
| Prescriber's Specialty: | |

Recertification is Required Annually

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