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