



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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