VIVA MEDICARE

417 20th Street North Suite 1100
Birmingham, AL 35203
Fax Number: (205) 558-7506

Coverage Criteria: The patient has been advised to report any changes to the prescriber such as changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide, while taking Chantix.
Coverage Duration: 6 Months

CHANTIX 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:**

Medication and Diagnosis Information:		
Medication:	**Strength:**	
Route:	**Frequency:**	**Quantity:**

Coverage Criteria Questions:		
ICD Code/Diagnosis:		
1. Is Chantix being used as an aid to smoking cessation or for nicotine withdrawal?	**Yes**	**No**
2. If the patient is diagnosed with a condition not mentioned in #1, please explain.		
3. Has the patient been advised to report any changes to the prescriber such as changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide, while taking Chantix.	**Yes**	**No**

Additional Comments:

Request Type:	Required Information:
☐ **Prior Authorization**	**View Prior Authorization & Step Therapy Criteria at:** **www.vivamedicaremember.com/Resource/Current/Formulary.aspx**
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

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

Request for Expedited Review:
☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: _____