VIVA HEALTH®
PHARMACY

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

Commercial Pharmacy Coverage Determination Form

***** Please note any incomplete information may result in a denial *****

Patient Information:	**Prescriber Information:**
Patient Name:	Prescriber:
Member ID #:	Office Phone #:
Date of Birth:	Office Fax #:
Phone #:	NPI #:
Address:	Office Contact:

View Commercial Plan Formulary at: http://www.vivahealth.com/provider/resources

Medication and Diagnosis Information:

Medication:_____ Strength:_____

Must check one: ☐ Brand ☐ Generic Route:_____

Frequency:_____ Quantity: _____

Diagnosis:_____

Alternate Drug(s) Previously Tried or Contraindicated:

Drug:	Date(s) Used:	Outcome:
Drug:	Date(s) Used:	Outcome:
Drug:	Date(s) Used:	Outcome:

Rationale for Request: (Please attach relevant labs and clinic notes)

Prescriber or Authorized Representative Signature:

Signature: Date:

Prescriber Specialty: ☐ Request for expedited review

Revised: 1/17/2020