



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: <input type="checkbox"/> Brand <input type="checkbox"/> 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: _____	<input type="checkbox"/> Request for expedited review

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