VIVA MEDICARE PHARMACY

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

MEDICARE PART D 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 #:	NPI #:
Address:	Office Contact:

Medication and Diagnosis Information:

Medication:		Strength:
Route:	Frequency:	Quantity:

If Injectable or Nebulized Medication, where is it being administered?

- ☐ Home (Self –Administered)
- ☐ Long-Term Care
- ☐ Skilled Nursing Facility
- ☐ Provider's Office (From Provider's Stock)
- ☐ Provider's Office (Patient Provides)

Diagnosis: (Please attach all office notes and labs supporting diagnosis)

Alternate drug(s) previously tried or contraindicated:

Drug:	Date(s) used:	Outcome:
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Rationale for request:

Request Type:	Required Information:
☐ **Prior Authorization** *OR* ☐ **Step Therapy**	**View Prior Authorization & Step Therapy Criteria at:** http://www.vivamedicaremember.com/memberresources/default.aspx#Formularies
☐ **Formulary Exception**	Request for a drug that is not on the plan's list of covered drugs. The prescriber must provide information that, given the patient's medical condition, all covered Part D drugs on any tier of the plan's formulary would not be as effective and/or would have adverse side effects.
☐ **Quantity Exception**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide documentation that the restricted dose has been found to be ineffective OR based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
☐ **Tier Exception**	Request for an exception to the tier level for a covered drug. The prescriber must provide documentation that the drug in the lower-cost sharing tier for the treatment of the member's condition would not be as effective as the requested drug in the higher cost-sharing tier and/or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or for drugs approved as a formulary exception.

Prescriber's or Authorized Representative Signature:

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's ability to regain maximum function.

Please provide an after-hours contact and direct phone number: ____

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