



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 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:	
Medication and Diagnosis Information:			
Medication: _____		Strength: _____	
Must check one: <input type="checkbox"/> Brand <input type="checkbox"/> Generic		Route: _____	
Frequency: _____		Quantity: _____	
If Injectable or Nebulized: where is being administered? Must check one:			
<input type="checkbox"/> Home (Self-Administered)		<input type="checkbox"/> Long-Term Care	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Provider's Stock (Buy & Bill)		<input type="checkbox"/> Provider's Office (Patient Provides)	
Diagnosis: (Please attach all office notes and labs supporting diagnosis)			

Request for Expedited Review:
<input type="checkbox"/> 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 afterhours contact and direct number: _____

Confidentiality Notice: The information transmitted with this facsimile is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message in error, please notify us immediately and destroy the related message.

View Plan Formulary, Prior Authorization and Step Therapy Criteria at:

<https://www.vivahealth.com/medicare/MemberResources/>

Exception requests require the patient to have tried and failed the following:

- ✓ 1 formulary alternative if there are 1-3 formulary alternatives available
- ✓ 2 formulary alternatives if there are 4-6 formulary alternatives available
- ✓ 3 formulary alternatives if there are greater than 6 formulary alternatives available

***** Please provide a complete supporting statement under the applicable request *****

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 Limit 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. _____

Alternative drugs tried and failed:

Drug #1

Drug #2

Drug #3

Drug #4

Drug #5

Prescriber or Authorized Representative Signature:

Signature:

Date: