



Medication Prior Authorization / Exceptions Request Form
Fax form to: (866) 265-5511

To ensure a timely response, please fill out form completely and legibly. An incomplete form may be returned. Please submit clinical information as needed to support medical necessity of the request. Requests will not be processed if any of the following information is missing: member information, provider information or clinical documentation (chart notes). For any questions, please contact Vivida Health by phone at: (844) 716-5385.

Form with fields for Today's Date, Medicaid checkbox, Member Information (Last Name, First Name, ID Number, Date of Birth), Provider Information (Name, Specialty & NPI number, Phone Number, Fax Number), and Review Type (Initial Review, Reauthorization).

- 1. Medication Requested: (Include name, strength, directions and quantity)
2. Estimated duration of therapy:
3. ICD-10 Code/Diagnosis description for requested medication:
4. Previous formulary medication trial and failures: (Length of treatment/outcome with dates must be supported in clinical documentation (chart notes). Use of pharmaceutical samples cannot be accepted as justification.)

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