pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COPD AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **COPD Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: *(*Requests for Daliresp – please use "Daliresp" prior authorization form)*	☐Anoro Ellipta ☐Combivent Respimat ☐Incruse Ellipta ☐Lonhala Magnair starter kit ☐Lonhala Magnair refill kit ☐Seebri Neohaler	☐Spiriva Handihaler *(preferred with clinical PA)* ☐Spiriva Respimat ☐Stiolto Respimat ☐Trelegy Ellipta ☐Utibron Neohaler ☐ _____

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code *(required)*:	

COPD DIAGNOSIS	
1. Did the beneficiary try and fail the preferred COPD Agents? ☐Atrovent HFA ☐ipratropium nebulizer vials ☐Spiriva Handihaler ☐Bevespi Aerosphere HFA ☐ipratropium/albuterol nebs ☐Tudorza Pressair	☐Yes ☐No *Submit medical record documentation of beneficiary's medication regimen and response to treatment.*
2. Does the beneficiary have a contraindication or intolerance to any of the preferred COPD Agents listed in question (1)?	☐Yes ☐No *Submit medical record documentation of contraindications/intolerances.*

ASTHMA DIAGNOSIS	
1. Is this request for a tiotropium-containing agent?	☐Yes ☐No – *Submit medical literature supporting the use of the requested agent for the treatment of asthma.*
2. Is the beneficiary 6 years of age or older?	☐Yes ☐No
3. Is the beneficiary currently receiving optimally titrated doses of both of the following? ☐inhaled glucocorticoid ☐long-acting beta-agonist (LABA)	☐Yes ☐No *Submit medical record documentation of beneficiary's medication regimen and response to treatment.*
4. Does the beneficiary have a contraindication or intolerance to optimally titrated doses of both of the following? ☐inhaled glucocorticoid ☐long-acting beta-agonist (LABA)	☐Yes ☐No *Submit medical record documentation of contraindications/intolerances.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: