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

DALIRESP (roflumilast) PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Daliresp (roflumilast), please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **COPD Agents** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request ☐Additional info (PA#:_____) # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Daliresp 500 mcg tablet **Directions:** ☐one tablet daily ☐other (specify): _____

Quantity: | Refills: | Diagnosis: | Dx code *(required)*: _____

SECTION A: INITIAL REQUESTS

1. Does the Recipient have a diagnosis of severe COPD as evidenced by all of the following? ☐medical history ☐forced expiratory volume / FEV_1 ☐FEV_1 / FVC ratio ☐physical exam ☐forced vital capacity / FVC	☐Yes ☐No *Submit documentation of medical history, physical exam, and pulmonary function tests (FEV_1 & FVC)*
2. Does the Recipient have a diagnosis of chronic bronchitis with documented cough and sputum production for at least 3 months in the past 2 consecutive years?	☐Yes – *submit documentation* ☐No
3. Have other causes of chronic airflow limitations been ruled out? ☐asthma ☐bronchiectasis ☐heart failure ☐tuberculosis	☐Yes ☐No *Submit documentation of medical history, physical exam, and pulmonary function tests*
4. Is the Recipient taking maximum therapeutic doses of, or have an intolerance or contraindication to, regularly scheduled use of the following? *Check all that apply.* ☐long-acting inhaled beta-2 agonist (ex. Serevent, Foradil) ☐preferred long-acting inhaled anticholinergic (ex. Spiriva, Tudorza) ☐inhaled corticosteroid (ex. Flovent, Qvar, Pulmicort, Asmanex, Breo) ☐combination product containing 2 of the above (ex. Advair, Dulera, Symbicort, Stiolto, Anoro)	☐Yes – *submit medical record documentation of current, complete medication list* ☐No – *submit documentation of intolerances or contraindications to listed medications/drug classes*
5. Has the Recipient experienced 2 or more COPD exacerbations in the past year that required Emergency Dept. visits, hospitalization, or treatment with oral steroids?	☐Yes ☐No *Submit medical record documentation of all exacerbations*
6. Does the Recipient have moderate or severe liver impairment (Child-Pugh B or C)?	☐Yes ☐No *Submit results of recent liver function tests (LFTs)*
7. Is the Recipient taking a strong CYP3A4 inducer? ☐carbamazepine ☐efavirenz ☐oxcarbazepine ☐phenytoin ☐dexamethasone ☐nevirapine ☐phenobarbital ☐rifampin	☐Yes ☐No *Submit documentation of Recipient's complete current medication list*
8. *If the Recipient has a history of anxiety, bipolar disorder, depression, schizophrenia, substance use disorder, personality disorder, or prior suicide attempt*, was the Recipient evaluated, treated, and determined to be a candidate for Daliresp by a psychiatrist?	☐Yes – *submit medical record documentation of psychiatric evaluation & treatment* ☐No

SECTION B: RENEWAL REQUESTS

1. Has the Recipient experienced improvement in the signs and symptoms of COPD as evidenced by all of the following? ☐FEV_1 ☐FEV_1/FVC ratio ☐decreased frequency of COPD exacerbations	☐Yes – *submit medical record documentation of improvement in Recipient's condition* ☐No
2. Has the Recipient had a mental health screening since the last authorization of Daliresp, including an evaluation for suicidal thoughts or ideations?	☐Yes – *submit medical record documentation of screening/evaluation performed since last approval* ☐No
3. Is the Recipient taking a strong CYP3A4 inducer? ☐carbamazepine ☐efavirenz ☐oxcarbazepine ☐phenytoin ☐dexamethasone ☐nevirapine ☐phenobarbital ☐rifampin	☐Yes ☐No *Submit documentation of Recipient's complete current medication list*

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

Prescriber Signature:	**Date**: