DALIRESP (roflumilast) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for COPD Agents and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

**PRIOR AUTHORIZATION INFORMATION**

<table>
<thead>
<tr>
<th>New request</th>
<th>Additional info (PA#:_________)</th>
<th>Prescriber name:</th>
</tr>
</thead>
</table>

**BENEFICIARY INFORMATION**

<table>
<thead>
<tr>
<th>Name of office contact:</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact’s phone number:</td>
<td>State license #:</td>
</tr>
<tr>
<td>LTC facility contact/phone:</td>
<td>NPI: MA Provider ID#:</td>
</tr>
</tbody>
</table>

**CLINICAL INFORMATION**

<table>
<thead>
<tr>
<th>Medication requested: Daliresp 500 mcg tablet</th>
<th>Directions: one tablet daily</th>
<th>Other (specify):</th>
</tr>
</thead>
</table>

**SECTION A: INITIAL REQUESTS**

1. Does the beneficiary have a diagnosis of severe COPD as evidenced by all of the following? 
   - medical history
   - forced expiratory volume / FEV₁
   - physical exam
   - forced vital capacity / FVC
   - No

2. Does the beneficiary have a diagnosis of chronic bronchitis with documented cough and sputum production for at least 3 months in the past 2 consecutive years?
   - Yes

3. Have other causes of chronic airflow limitations been ruled out?
   - asthma
   - bronchiectasis
   - heart failure
   - tuberculosis
   - Yes

4. Is the beneficiary 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, Duera, Symbicort, Stiolto, Anoro)
   - Yes – submit documentation

5. Has the beneficiary experienced 2 or more COPD exacerbations in the past year that required Emergency Dept. visits, hospitalization, or treatment with oral steroids?
   - Yes

6. Does the beneficiary have moderate or severe liver impairment (Child-Pugh B or C)?
   - Yes

7. Is the beneficiary taking a strong CYP3A4 inducer?
   - carbamazepine
   - efavirenz
   - oxcarbazepine
   - phenytoin
   - dexamethasone
   - nevirapine
   - phenobarbital
   - rifampin
   - Yes

8. If the beneficiary 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

**SECTION B: RENEWAL REQUESTS**

1. Has the beneficiary experienced improvement in the signs and symptoms of COPD as evidenced by all of the following?
   - FEV₁
   - FEV₁/FVC ratio
   - decreased frequency of COPD exacerbations
   - Yes – submit medical record documentation of improvement in beneficiary’s condition

2. Has the beneficiary 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

3. Is the beneficiary taking a strong CYP3A4 inducer?
   - Yes

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

<table>
<thead>
<tr>
<th>Prescriber Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

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Form effective 1/20/16