

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		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	Prescriber name:	
<input type="checkbox"/> Renewal request	# of pages in request: _____		
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:	<input type="checkbox"/> Daliresp 500 mcg tablet	Directions:	<input type="checkbox"/> one tablet daily	<input type="checkbox"/> other (specify): _____
Quantity:	Refills:	Diagnosis:	Dx code (required): _____	

SECTION A: INITIAL REQUESTS

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

SECTION B: RENEWAL REQUESTS

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

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

Prescriber Signature:	Date:
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