iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

Provider Help Desk
1.866.399.0928

FAX Completed Form To
1.877.386.4695

REQUEST FOR PRIOR AUTHORIZATION
ROFLUMILAST (DALIRESP™)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___|___|___|___| Patient Name: ____________________________________ DOB: __________________

Patient Address:____

Provider NPI: |___|___|___|___|___|___|___|___|___|___|___|___|___| Prescriber Name:_______________________________ Phone:_________________

Prescriber Address:____ Fax:____________________

Pharmacy Name:_____________________________ Address:_______________________________________ Phone:_________________

Pharmacy

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

NPI: |___|___|___|___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____________________ NDC : |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met: 1) A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2) A smoking history of ≥ 20 pack-years, and 3) Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4) A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

<u>Non-Preferred</u>

☐ Daliresp™

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
________	________________________	_________	_________

Diagnosis: ____

Treatment failure with long-acting bronchodilator and inhaled corticosteroid:

Long-Acting Bronchodilator Trial: Drug Name: ____

Trial Drug Strength & Dosing Instructions: ___________________________Trial start & end dates: __________________

Reason for failure: ____

Inhaled Corticosteroid Trial: Drug Name: ____

Trial Drug Strength & Dosing Instructions: ___________________________Trial start & end dates: __________________

Reason for failure: ____

Date of most recent spirometry test: ____

Smoking history of ≥ 20 pack-years: ☐ Yes ☐ No

History of at least one exacerbation in past year requiring treatment with oral glucocorticosteroids: Date of exacerbation: ____________ Glucocorticosteroid Trial (drug name & dose):

____

Possible drug interactions/conflicting drug therapies:____
Attach lab results and other documentation as necessary.

Prescriber Signature: ____ Date of Submission: _______________________
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.