FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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: _____

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

Pharmacy

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.

Non-Preferred

☐ 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.*