Prior Authorization Request Form for COPD Agents

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Has all potential drug interactions been addressed by the prescriber (such as discontinuation, dose reduction of the interacting drug, or counseled the member of the risks associated with the use of both medications when they interact)?	☐ Yes ☐ No	*Submit current complete medication list.*
Does the member have a history of a contraindication to the requested medication?	☐ Yes ☐ No	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred COPD agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. another drug in the same class or dose different from the agent being requested):

- ☐ Is being transitioned to another drug in the same class with the intent of discontinuing one of the medications
- ☐ Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

INITIAL REQUEST FOR DALIRESP:

- ☐ Member has severe COPD according to the current GOLD guidelines
- ☐ Member has severe COPD based on medical history, physical exam findings and lung function tests (forced expiratory volume (FEV1) <50% of predicted)_____
- ☐ Member has chronic bronchitis with cough and sputum production for at least 3 months per year in consecutive 2 years
- ☐ Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc

- ☐ Member has experienced more than 2 COPD exacerbations per year that required an ED visit, hospitalization, or use of oral steroids despite maximum therapeutic doses of or intolerance or contraindication to regular scheduled medications (listed below), dates of recent exacerbations:_____
- ☐ Member is using or cannot use maximum tolerated doses of ALL of the following (in either a single-ingredient or combination product): (medication, start date)
    - ☐ Inhaled long-acting beta 2 agonist (LABA): _____
    - ☐ Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA): _____
    - ☐ Inhaled corticosteroid:_____
- ☐ Does not have suicidal ideation
- ☐ Member has a history of suicide attempt(s), bipolar disorder, major depressive disorder, schizophrenia, substance use disorder(s), anxiety disorder(s), borderline personality disorder, and/or antisocial personality disorder
    - ☐ Was evaluated and treated for above mental health condition(s) by a psychiatrist
    - ☐ Psychiatrist has determined the member is a candidate for treatment with Daliresp
- ☐ Member does not have a history of the above mental health conditions
    - ☐ Prescriber performed a mental health evaluation

RENEWAL REQUIEST FOR DALIRESP:

- ☐ FEV1 and FEV1/forced vital capacity (FVC) ratio have improved since starting Daliresp:_____
- ☐ Frequency of COPD exacerbations has decreased since starting Daliresp (number of exacerbations in last year):_____
- ☐ Does not have suicidal ideations
- ☐ Was evaluated for new onset or worsening symptoms of anxiety or depression
    - ☐ If applicable, is being treated for these mental health conditions and determined to be a candidate for treatment with Daliresp

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)