Prior Authorization Request Form for COPD Agents

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact 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: _____

Does the member have 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 Medication Taken Previously (start and end date and dose):_____ _____ _____ _____

☐ 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):

- ☐ For an inhaled glucocorticoid, is being titrated to or tapered from another inhaled glucocorticoid
- ☐ For an inhaled long-acting anticholinergic, is being titrated to or tapered from another inhaled long-acting anticholinergic
- ☐ For an inhaled long-acting beta-agonist, is being titrated to or tapered from another inhaled long-acting beta-agonist
- ☐ Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines-supporting evidence:

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 1 of the following:_____

- ☐ For members with an eosinophil count ≥ 100cells/microliter, maximum therapeutic doses of or intolerance or contraindication to regular scheduled use of ALL of the following:
  - ☐ Inhaled long-acting beta 2 agonist (LABA): _____
  - ☐ Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA): _____
  - ☐ Inhaled corticosteroid:_____
- ☐ For members with an eosinophil count < 100cells/microliter, maximum therapeutic doses of or intolerance or contraindication to regular scheduled use of ALL of the following:
  - ☐ Inhaled long-acting beta 2 agonist (LABA): _____
  - ☐ Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA): _____

☐ 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:

☐ 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:

Pharmacy Department 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.)