pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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.

☐New request ☐Renewal request # of pages: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:	Directions:
Quantity:	Refills:	Diagnosis:	Dx code *(required)*:

INITIAL Requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has COPD that is severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
☐Has chronic bronchitis with cough and sputum production for at least 3 months per year in 2 consecutive years
☐Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc.
☐Experienced more than 2 COPD exacerbations per year that required an ED visit, hospitalization, or use of oral steroids
☐Is using or cannot use maximum tolerated doses of the following (in either a single-ingredient or combination product – submit medication list):
- ☐Inhaled long-acting beta 2 agonist (LABA)
- ☐Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA)
- ☐Inhaled corticosteroid (unless beneficiary has an eosinophil count <100 cells/microliter – *submit documentation of lab results*)

☐Does not have moderate or severe liver impairment (Child-Pugh B or C)
☐Does not have suicidal ideations
☐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 this/these mental health condition(s) by a psychiatrist
- ☐Is a candidate for treatment with Daliresp as determined by a psychiatrist

☐Does not have a history of the above mental health conditions
- ☐Had a mental health evaluation performed by the prescriber

RENEWAL Requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Frequency of COPD exacerbations has decreased since starting Daliresp
☐Does not have suicidal ideations
☐Was evaluated for new onset or worsening symptoms of anxiety and depression
- ☐If applicable, is being treated for these mental health conditions and determined to be a candidate for treatment with Daliresp

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

Prescriber Signature:	Date: