



PRIOR AUTHORIZATION REQUEST

Daliresp

PATIENT: Name _____
Address: _____
City, State, Zip _____
D.O.B. _____
Member ID: _____

Prescriber: Name _____
Address _____
City, State, Zip _____
Phone _____
Fax _____
NPI _____

Medication Requested: *Daliresp*

Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
 INITIAL → *please answer questions 2-7*
 CONTINUATION → *please proceed to question 8*
2. Yes No Is this medication being prescribed by, or consultation with, a pulmonologist?
3. Yes No Does the patient have a diagnosis of severe COPD with chronic bronchitis with FEV1 LESSTHAN or EQUAL to 50%, that has been predicted based on post-bronchodilator FEV1?
4. Yes No Is there documentation of symptomatic exacerbations within the last year while compliant with dual long-acting bronchodilator treatment [long-acting beta-agonist (LABA) plus long-acting muscarinic antagonist (LAMA)] for at least 3 months?
5. Yes No Will the requested medication be used in conjunction with a LABA and LAMA unless contraindicated/intolerant to it?
6. Yes No Will the requested medication be used in combination with theophylline?
7. Yes No Is there any evidence of moderate to severe liver impairment (Child-Pugh B or C)?
8. Yes No Has the patient improved in the number of COPD exacerbations?

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**If you have any
questions, call:
800-753-2851**



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Please document the diagnoses, symptoms, and/or any other information important to this review:

Two horizontal lines for documentation.

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851