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?

Continued on Page 2

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

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Continued from Page 1

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

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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