PRIOR AUTHORIZATION REQUEST

Daliresp

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient 40 years of age or older? [If no, no further questions.]	Yes	No
2	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? [] INITIAL (If checked, go to 3) [] CONTINUATION (If checked, go to 11)		
3	Is this medication being prescribed by, or consultation with, a pulmonologist?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If no, no further questions.]		
4	Does the patient have a diagnosis of severe chronic obstructive pulmonary disease (COPD) with chronic bronchitis? [If no, no further questions.]	Yes	No
5	Does the patient have a forced expiratory volume in one second (FEV1) LESS THAN or EQUAL to 50% predicted based on post-bronchodilator FEV1? [If no, no further questions.]	Yes	No
6	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? [If no, no further questions.]	Yes	No
7	Will the requested medication be used in conjunction with a long-acting beta-agonist (LABA) plus long-acting muscarinic antagonist (LAMA)? [If yes, skip to question 9.]	Yes	No
8	Is the patient contraindicated or intolerant to therapy with a long-acting beta-agonist (LABA) plus long-acting muscarinic antagonist (LAMA)? [If no, no further questions.]	Yes	No
9	Will the requested medication be used in combination with theophylline? [If yes, no further questions.]	Yes	No
10	Is there any evidence of moderate to severe liver impairment (Child-Pugh B or C)? [No further questions.]	Yes	No
11	What is the diagnosis or indication? [] Chronic obstructive pulmonary disease (COPD) with chronic bronchitis (If checked, go to 12) [] All other diagnoses (If checked, no further questions)		
12	Has the patient improved in the number of chronic obstructive pulmonary disease (COPD) exacerbations?	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

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