

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Daliresp[®] (roflumilast)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Daliresp 500 mcg

Dose: 1 tablet by mouth once daily

New – Complete Section A

Continuation – Complete Section B

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Daliresp[®] (roflumilast) requires the following information to certify:

Patient must have met the following requirements:

Note: initial authorization, when given, is limited to a 180 day supply.

- Diagnosis of Stage 3 or 4 Chronic Obstructive Pulmonary Disease (COPD) with chronic bronchitis (a productive, long-term cough that lasts 3 months out of the year for 2 consecutive years)
- History of repeated exacerbations (a minimum of 3 exacerbations in the previous 3 years)
- Patient must be age 40 or older
- Documented trial of at least a 4-week with an inhaled corticosteroid
- Documented trial and clinical failure with maximum dosages of inhaled corticosteroids and long-acting beta agonists

For continuation, patient must have met the following requirements:

- Patient has demonstrated clinically meaningful improvement

SECTION A – NEW THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Daliresp[®] (roflumilast) requires the following information to certify:

A. What is the patient's diagnosis?

- a. Stage 3 (Severe) COPD
b. Stage 4 (Very Severe) COPD
c. Other: _____

Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. Does the patient have chronic bronchitis (a productive, long-term cough that lasts 3 months out of the year for 2 consecutive years)?

- Yes
 No

C. How many COPD-related exacerbations has the patient experienced in the previous 3 years?

- 2 or less – Rationale for use: _____
 3
 4 or more

D. Is the patient 40 years of age or older?

- Yes
 No – Rationale for use: _____

E. Have maximum dosages of inhaled corticosteroids (ICS) and long-acting beta agonists (LABA) been used in this patient?

- Yes
Has an ICS been used for a minimum of 4 weeks?
 Yes
 No
 No – Rationale for use: _____

WARNING

Psychiatric Events including Suicidality: Advise patients, their caregivers, and families to be alert for the emergence or worsening of insomnia, anxiety, depression, suicidal thoughts or other mood changes, and if such changes occur to contact their healthcare provider. Carefully weigh the risks and benefits of treatment with Daliresp[®] in patients with a history of depression and/or suicidal thoughts or behavior.

SECTION B – CONTINUATION

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Daliresp[®] (roflumilast) requires the following information to certify:

A. The patient has demonstrated clinically meaningful improvement since the time Daliresp therapy was initiated?

- Yes
 No

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX