

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Daliresp[®] (roflumilast)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug product: Daliresp 500 mcg
 Start date (or date of next dose): _____
 Date of last dose (if applicable): _____
 Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must have severe COPD associated with chronic bronchitis
2. Must be using Daliresp to reduce the risk of COPD exacerbations
3. Must be age 18 or older
4. Must have a history of repeated COPD exacerbations (a minimum of 3 exacerbations in the previous 3 years)
5. Must have a documented trial of at least 4 weeks with an inhaled corticosteroid
6. Must have a documented trial and clinical failure with maximally tolerated doses of 1 inhaled corticosteroid and 1 long-acting beta-agonist

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- Severe COPD
 Other – the patient's condition is: _____

B. Does the patient have chronic bronchitis?

- Yes No; **Rationale for use:** _____

C. Is Daliresp being used to reduce the risk of COPD exacerbations?

- Yes No; **Rationale for use:** _____

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

- 0 1 2 3 or more

E. Has the patient tried an inhaled corticosteroid for at least 4 weeks?

- Yes. Please list below:

Drug	Dosage	Dates (or length of therapy)
_____	_____	_____
_____	_____	_____

- No, **Rationale for use:** _____

F. Has the patient tried and failed 1 inhaled corticosteroid and 1 inhaled long-acting beta agonist at the maximally tolerated dose?

- Yes. Please list below:

Drug	Dosage	Dates (or length of therapy)
_____	_____	_____
_____	_____	_____

- No, **Rationale for use:** _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Daliresp likely be the most effective option for this patient?

- Yes No

If yes, please explain why: _____

If the patient is currently using Daliresp, would changing the patient's current regimen likely result in adverse effects for the patient?

Yes No

If yes, please explain: _____

