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 ☐ Daliresp 250 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 be used for a medically accepted indication*
2. Must have an FEV1 < 50%
3. Must have had > 1 COPD exacerbation in the past year
4. Must be age 18 or older
5. Must have tried and failed* triple therapy with an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), *and* a long-acting antimuscarinic (LAMA) in the past 6 months

* Failure is defined as no improvement, a worsening of the condition, or an intolerance after trying triple therapy at the maximum dosages for at least 4 weeks consistently

For continuation, patient must have met the following requirements:

1. Must provide documentation showing a reduction in COPD exacerbations

Additional information

Note: When coverage criteria are met, coverage duration is 1 year.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2020
Last reviewed 01/2020

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?

☐ COPD
☐ *Other – the patient's condition is:* _____
Rationale for Other use: _____

B. Has the patient had more than 1 COPD exacerbation in the past year?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: _____
☐ No

C. Is the patient's FEV1 < 50%?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: _____
☐ No

D. Has the patient <u>tried</u> triple therapy with an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), *and* long-acting antimuscarinic (LAMA) in the past 6 months?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: _____
☐ No

E. Has the patient <u>failed</u>* triple therapy with an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), *and* long-acting antimuscarinic (LAMA) in the past 6 months?

☐ Yes
☐ No. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: _____
☐ No

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Last reviewed 01/2020

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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: _____

_____

_____

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Last reviewed 01/2020