



Prior Authorization Request Form for COPD Agents

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermyeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:	Member Name:		
Prescriber Specialty:	Identification #:		
NPI:	Group #:		
Office Contact Name:	Date of Birth:		
Fax #:	Medication Allergies:		
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:	
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Does the member have a contraindication to the requested medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred COPD agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes Medication Taken Previously (start and end date and dose): _____ <input type="checkbox"/> No _____		
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____			
Therapeutic Duplication: If concurrently prescribed a therapeutic duplicate (i.e. another drug in the same class or dose different from the agent being requested): <ul style="list-style-type: none"> <input type="checkbox"/> For an inhaled glucocorticoid, is being titrated to or tapered from another inhaled glucocorticoid <input type="checkbox"/> For an inhaled long-acting anticholinergic, is being titrated to or tapered from another inhaled long-acting anticholinergic <input type="checkbox"/> For an inhaled long-acting beta-agonist, is being titrated to or tapered from another inhaled long-acting beta-agonist <input type="checkbox"/> Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines-supporting evidence: _____ 			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM. INITIAL REQUEST FOR DALIRESP: <ul style="list-style-type: none"> <input type="checkbox"/> Member has severe COPD according to the current GOLD guidelines <input type="checkbox"/> Member has severe COPD based on medical history, physical exam findings and lung function tests (forced expiratory volume (FEV1) <50% of predicted) _____ <input type="checkbox"/> Member has chronic bronchitis with cough and sputum production for at least 3 months per year in consecutive 2 years <input type="checkbox"/> Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc <input type="checkbox"/> Member has experienced more than 2 COPD exacerbations per year that required an ED visit, hospitalization, or use of oral steroids despite 1 of the following: _____ 			

- For members with an eosinophil count \geq 100cells/microliter, maximum therapeutic doses of or intolerance or contraindication to regular scheduled use of ALL of the following:
 - Inhaled long-acting beta 2 agonist (LABA): _____
 - Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA): _____
 - Inhaled corticosteroid: _____
- For members with an eosinophil count $<$ 100cells/microliter, maximum therapeutic doses of or intolerance or contraindication to regular scheduled use of ALL of the following:
 - Inhaled long-acting beta 2 agonist (LABA): _____
 - Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA): _____
- Does not have suicidal ideation
- Member has a history of suicide attempt(s), bipolar disorder, major depressive disorder, schizophrenia, substance use disorder(s), anxiety disorder(s), borderline personality disorder, and/or antisocial personality disorder
 - Was evaluated and treated for above mental health condition(s) by a psychiatrist
 - Psychiatrist has determined the member is a candidate for treatment with Daliresp
- Member does not have a history of the above mental health conditions
 - Prescriber performed a mental health evaluation

RENEWAL REQUEST FOR DALIRESP:

- Frequency of COPD exacerbations has decreased since starting Daliresp (number of exacerbations in last year): _____
- Does not have suicidal ideations
- Was evaluated for new onset or worsening symptoms of anxiety or depression
 - If applicable, is being treated for these mental health conditions and determined to be a candidate for treatment with Daliresp

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:
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Pharmacy Department will respond via fax or phone within 24 hours.
 Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)