Request for Prior Authorization
Roflumilast (Daliresp)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for roflumilast (Daliresp). Payment will be considered for patients 18 years of age or older when the following is met: 1) A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2) A smoking history of ≥ 20 pack-years, and 3) Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4) A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred **Non-Preferred**

☐ **Roflumilast** ☐ **Daliresp**

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis: _____

Treatment failure with long-acting bronchodilator and inhaled corticosteroid:

Long-Acting Bronchodilator Trial: Drug Name: _____

Trial Drug Strength & Dosing Instructions: _____Trial start & end dates: _____

Reason for failure: _____

Inhaled Corticosteroid Trial: Drug Name: _____

Trial Drug Strength & Dosing Instructions: _____Trial start & end dates: _____

Reason for failure: _____

Date of most recent spirometry test: _____

Smoking history of ≥ 20 pack-years: ☐ Yes ☐ No

History of at least one exacerbation in past year requiring treatment with oral glucocorticosteroids:
Date of exacerbation: _____ Glucocorticosteroid Trial (drug name & dose): _____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.