REALRx

PRIOR AUTHORIZATION REQUEST FORM
DALIRESP®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Daliresp® (roflumilast)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Does the member have a diagnosis of severe COPD?	☐	☐	**Please provide documentation**
3. Has the member tried and failed OR have a contraindication to an inhaled long-acting beta agonist or an inhaled long-acting anticholinergic or combination product?	☐	☐	**Please provide documentation**
4. Has the member tried and failed OR have contraindication to an inhaled corticosteroid?	☐	☐	**Please provide documentation**
5. Does documentation show at least 1 COPD exacerbation in the past 12 months despite the use of bronchodilators and inhaled corticosteroids?	☐	☐	**Please provide documentation**
6. Does the member have moderate to severe liver impairment (Child-Pugh B or C)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a positive clinical response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-020
Origination Date: 01/23/2018
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023

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