**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Chronic Obstructive Pulmonary Disease (COPD) Agent

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *HPP's maximum approval time is 12 months but may be less depending on the drug.* | | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
***Please answer the following questions and sign.***

Q1. The request is for renewal of Daliresp (roflumilast) that was previously approved. If YES, go to 13. If NO, go to 2.

☐ Yes ☐ No

Q2. The request is for Daliresp (roflumilast). If YES, go to 3. If NO, go to 12.

☐ Yes ☐ No

Q3. For Daliresp (roflumilast), the member has a diagnosis of severe COPD as documented by medical history, physical exam findings, and lung function testing (forced expiratory volume [FEV1] <50% of predicted) that are consistent with severe COPD according to the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines on the diagnosis and management of COPD.

☐ Yes ☐ No

Q4. For Daliresp (roflumilast), the member has a diagnosis of chronic bronchitis as documented by cough and sputum production for at least three months in each of two consecutive years.

☐ Yes ☐ No

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Q5. For Daliresp (roflumilast), the member had other causes of their chronic airflow limitations excluded.

☐ Yes ☐ No

Q6. For Daliresp (roflumilast), for a beneficiary with an eosinophil count 100 cells/microliter: the member continues to experience more than two exacerbations of COPD per year requiring emergency department visits, hospitalization, or oral steroid use despite maximum therapeutic doses of or a contraindication or an intolerance to regular scheduled use of all of the following:

a) Long-acting inhaled beta agonist,
b) Long-acting inhaled anticholinergic,
c) Inhaled corticosteroid

☐ Yes ☐ No

Q7. For Daliresp (roflumilast), for a beneficiary with an eosinophil count <100 cells/microliter: the member continues to experience more than two exacerbations of COPD per year requiring emergency department visits, hospitalization, or oral steroid use despite maximum therapeutic doses of or a contraindication or an intolerance to regular scheduled use of both of the following:

a) Long-acting inhaled beta agonist
b) Long-acting inhaled anticholinergic,

☐ Yes ☐ No

Q8. The member does not have a contraindication to the prescribed drug.

☐ Yes ☐ No

Q9. The member does not have suicidal ideations.

☐ Yes ☐ No

Q10. For a beneficiary with a history of suicide attempt, bipolar disorder, major depressive disorder, schizophrenia, substance use disorder, anxiety disorder, borderline personality disorder, or antisocial personality disorder, was evaluated, treated, and determined to be a candidate for treatment with Daliresp (roflumilast) by a psychiatrist.

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☐ Yes ☐ No

Q11. For all other beneficiaries, had a mental health evaluation performed by the prescriber and determined to be a candidate for treatment with Daliresp (roflumilast).

☐ Yes ☐ No

Q12. For all other non-preferred COPD Agents, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred COPD Agents.

☐ Yes ☐ No

Q13. The member has a documented decrease in the frequency of COPD exacerbations.

☐ Yes ☐ No

Q14. The member does not have a contraindication to the prescribed drug.

☐ Yes ☐ No

Q15. The member does not have suicidal ideations.

☐ Yes ☐ No

Q16. The member was reevaluated and treated for new onset or worsening symptoms of anxiety and depression and determined to continue to be a candidate for treatment with Daliresp (roflumilast).

☐ Yes ☐ No

Q17. Additional Information:

Prescriber Signature

Date

*v2026*

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