Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

COPD Agents

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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. Is this a request for tiotropium (Spiriva, Spiriva Respimat)?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed for a diagnosis of asthma?

☐ Yes ☐ No

Q3. Is the patient of an appropriate age for the requested drug according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the patient currently receiving optimally tolerated doses of an inhaled glucocorticoid AND a long-acting beta agonist?

☐ Yes ☐ No

Q5. Does the patient have a contraindication to or intolerance of optimally titrated doses of an inhaled glucocorticoid AND a long-acting beta agonist?

☐ Yes ☐ No

Q6. Is this a request for Daliresp (roflumilast)?

☐ Yes ☐ No

Q7. Will the patient be taking any strong cytochrome P450 enzyme inducer such as, but not limited to, rifampin, phenobarbital, carbamazepine, or phenytoin?

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☐ Yes ☐ No

Q8. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q9. Does the patient have a documented improvement in the forced expiratory volume (FEV1) and forced expiratory volume/forced vital capacity ratio (FEV1/FVC) AND a decrease in the frequency of chronic obstructive pulmonary disease (COPD) exacerbations?

☐ Yes ☐ No

Q10. Does the patient have suicidal ideations?

☐ Yes ☐ No

Q11. Was the patient reevaluated and treated for any new onset or worsening symptoms of anxiety and depression AND was the patient determined to continue to be a candidate for treatment with Daliresp?

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of severe chronic obstructive pulmonary disease (COPD) as documented by ALL of the following: A) medical history, B) physical exam findings, C) lung function testing [forced expiratory volume (FEV1) less than 50 percent of predicted] that are consisted with severe chronic obstructive pulmonary disease (COPD) according to the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines on the diagnosis and management of chronic obstructive pulmonary disease (COPD)?

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of chronic bronchitis as documented by cough and sputum production for at least 3 months in each of 2 consecutive years?

☐ Yes ☐ No

Q14. Have other causes of the patient's chronic airflow limitations been excluded?

☐ Yes ☐ No

Q15. Does the patient continue to experience more than 2 exacerbations of chronic obstructive pulmonary disease (COPD) per year requiring emergency department visits, hospitalization, or oral steroid use despite maximum therapeutic doses of, intolerance of, or contraindication to regular scheduled use of ALL of the following: A) long-acting inhaled beta-2 agonist, B) a preferred long-acting inhaled anticholinergic, C) inhaled corticosteroid?

☐ Yes ☐ No

Q16. Does the patient have moderate to severe liver impairment (Child-Pugh class B or more severe)?

☐ Yes ☐ No

Q17. Does the patient have suicidal ideations?

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☐ Yes ☐ No

Q18. Does the patient have a history of a prior suicide attempt, bipolar disorder, major depressive disorder, schizophrenia, substance use disorders, anxiety disorders, borderline personality disorder, or antisocial personality disorder?

☐ Yes ☐ No

Q19. Has the patient been evaluated by, treated by, and determined to be a candidate for treatment with Daliresp (roflumilast) by a psychiatrist?

☐ Yes ☐ No

Q20. Has the patient had a mental health evaluation performed by the prescriber and been determined to be a candidate for treatment with Daliresp (roflumilast)?

☐ Yes ☐ No

Q21. Is the requested drug in the same class of drugs as a drug that the patient is already receiving (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q22. Is the patient being titrated to, or tapered from, another drug in the same class?

☐ Yes ☐ No

Q23. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q24. Is this a request for a preferred chronic obstructive pulmonary disease (COPD) drug (e.g., Anoro Ellipta, Atrovent, Bevespi Aerosphere, Combivent Respimat, ipratropium/albuterol nebulizer, ipratropium nebulizer, Spiriva Handihaler, Spiriva Respimat, Tudorza Pressair)?

☐ Yes ☐ No

Q25. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred chronic obstructive pulmonary disease (COPD) drugs (e.g., Anoro Ellipta, Atrovent, Bevespi Aerosphere, Combivent Respimat, ipratropium/albuterol nebulizer, ipratropium nebulizer, Spiriva Handihaler, Spiriva Respimat, Tudorza Pressair)?

☐ Yes ☐ No

Q26. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature Date

Updated for 2020