



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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 Daliresp (roflumilast)?

Yes No

Q2. Is this a request for a renewal of authorization for Daliresp?

Yes No

Q3. 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

Q4. 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

Q5. Have other causes of the patient's chronic airflow limitations been excluded?

Yes No

Q6. Does the patient continue to experience more than 2 exacerbations of 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) long-acting inhaled anticholinergic, C) inhaled corticosteroid?



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Patient Name: Prescriber Name:

Q7. Does the patient have a history of contraindication to the prescribed medication?
Q8. Have all potential drug interactions addressed by the prescriber...
Q9. Does the patient have suicidal ideations?
Q10. Does the patient have a history of a prior suicide attempt...
Q11. Has the patient been evaluated by, treated by, and determined to be a candidate for treatment with Daliresp...
Q12. Has the patient had a mental health evaluation performed by the prescriber...
Q13. Is the requested drug in the same class of drugs as a drug that the patient is already receiving...
Q14. Is the patient being transitioned to another drug in the same class...
Q15. Has the prescriber provided supporting peer reviewed literature...
Q16. Is this a request for a preferred chronic obstructive pulmonary disease (COPD) drug?

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Patient Name: Prescriber Name:

Q17. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred chronic obstructive pulmonary disease (COPD) drugs?

Yes checkbox

No checkbox

Q18. Does the patient have a documented improvement in the FEV1 and FEV1/forced vital capacity (FVC) ratio and a decrease in the frequency of COPD exacerbations?

Yes checkbox

No checkbox

Q19. Have all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact)?

Yes checkbox

No checkbox

Q20. Does the patient have a history of contraindication to the prescribed medication?

Yes checkbox

No checkbox

Q21. Does the patient have suicidal ideations?

Yes checkbox

No checkbox

Q22. Was the patient 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 checkbox

No checkbox

Q23. Additional Information:

Prescriber Signature

Date

Updated for 2021