GHP Family Pharmacy Customer Service
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Danville, PA 17822
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Geisinger

DALIRESP (roflumilast) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **COPD Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request # of pages: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:	Directions:
Quantity:	Refills:	Diagnosis:	Dx code *(required)*:

INITIAL Requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Has COPD that is severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
☐Has chronic bronchitis with cough and sputum production for at least 3 months per year in 2 consecutive years
☐Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc.
☐Experienced more than 2 COPD exacerbations per year that required an ED visit, hospitalization, or use of oral steroids
☐Is using or cannot use maximum tolerated doses of the following (in either a single-ingredient or combination product – submit medication list):
- ☐Inhaled long-acting beta 2 agonist (LABA)
- ☐Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA)
- ☐Inhaled corticosteroid (unless beneficiary has an eosinophil count <100 cells/microliter – *submit documentation of lab results*)

☐Does not have moderate or severe liver impairment (Child-Pugh B or C)
☐Does not have suicidal ideations
☐Has a history of suicide attempt(s), bipolar disorder, major depressive disorder, schizophrenia, substance use disorder(s), anxiety disorder(s), borderline personality disorder, and/or antisocial personality disorder
- ☐Was evaluated and treated for this/these mental health condition(s) by a psychiatrist
- ☐Is a candidate for treatment with Daliresp as determined by a psychiatrist

☐Does not have a history of the above mental health conditions
- ☐Had a mental health evaluation performed by the prescriber

RENEWAL Requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Frequency of COPD exacerbations has decreased since starting Daliresp
☐Does not have suicidal ideations
☐Was evaluated for new onset or worsening symptoms of anxiety and depression
- ☐If applicable, is being treated for these mental health conditions and determined to be a candidate for treatment with Daliresp

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**: