HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

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 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 have an eosinophil count greater than or equal to 100 cells/microliter and 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

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following:A) long-acting inhaled beta-2 agonist, B) long-acting inhaled anticholinergic, C) inhaled corticosteroid?

☐ Yes ☐ No

Q7. Does the patient have an eosinophil count less than 100 cells/microliter and 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?

☐ Yes ☐ No

Q8. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q9. Does the patient have suicidal ideations?

☐ Yes ☐ No

Q10. 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

Q11. 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

Q12. 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

Q13. Is the patient being transitioned to another drug in the same class with the intent of discontinuing one of the medications?

☐ Yes ☐ No

Q14. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q15. Is this a request for a preferred chronic obstructive pulmonary disease (COPD) drug?

☐ Yes ☐ No

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Q16. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred chronic obstructive pulmonary disease (COPD) drugs?

☐ Yes ☐ No

Q17. 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 ☐ No

Q18. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q19. Does the patient have suicidal ideations?

☐ Yes ☐ No

Q20. 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 ☐ No

Q21. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023