OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay the authorization process**.

Drug Requested: Daliresp® (roflumilast) **(Non-Preferred)**

DRUG INFORMATION: Complete information below to ensure authorization will **NOT** be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Length of Authorization: 1 yr

CLINICAL CRITERIA: All boxes **must** be checked to qualify or authorization process will be delayed.

- ❑ Patient has been diagnosed with severe COPD associated with chronic bronchitis and a history of exacerbations

AND

- ❑ Patient has tried and failed at least one first-line or second-line drug (inhaled anticholinergics, long-acting beta agonists or inhaled corticosteroids)

AND

- ❑ Adjunctive therapy (Daliresp® **must** be used in conjunction with first-line or second-line medication.)

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/30/2017; 8/28/2017;~~ **8/17/2018**