

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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*)

MEDICAID

DRUG INFORMATION: Complete information below. If incomplete, authorization process will 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.