AmeriHealth Caritas Iowa
Request for Prior Authorization

Roflumilast (Daliresp™)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met: 1) A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2) A smoking history of ≥ 20 pack-years, and 3) Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4) A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred: ☐ Daliresp™

Dosage Instructions:

Strength: Quantity: Days Supply:

Diagnosis:

Treatment failure with long-acting bronchodilator and inhaled corticosteroid:

Long-Acting Bronchodilator Trial:

Drug Name: Trial start & end dates:

Trial Drug Strength & Dosing Instructions:

Reason for failure:

Inhaled Corticosteroid Trial:

Drug Name: Trial start & end dates:

Trial Drug Strength & Dosing Instructions:

Reason for failure:

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Date of most recent spirometry test:

Smoking history of ≥ 20 pack-years: ☐ Yes ☐ No

History of at least one exacerbation in past year requiring treatment with oral glucocorticosteroids:

Date of exacerbation: Glucocorticosteroid Trial (drug name & dose):

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

<table>
<tr><td colspan="2">By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.</td></tr>
<tr><td>Prescriber signature:
(Must match prescriber listed above.)</td><td>Date of submission:</td></tr>
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Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.