

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.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:		Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

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

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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 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

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<p>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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q13. Is the patient being transitioned to another drug in the same class with the intent of discontinuing one of the medications?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q14. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q15. Is this a request for a preferred chronic obstructive pulmonary disease (COPD) drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q16. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of the preferred chronic obstructive pulmonary disease (COPD) drugs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q18. Does the patient have a history of contraindication to the prescribed medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q19. Does the patient have suicidal ideations?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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Member Name: Prescriber Name:

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

v2025