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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Daliresp (roflumilast)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION 2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Daliresp (roflumilast)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes	☐ No	Patient has a diagnosis of severe COPD with chronic bronchitis as documented by spirometry results
☐ Yes	☐ No	Patient has a smoking history of greater than or equal to 20 pack-years
☐ Yes	☐ No	Patient is currently on a long-acting bronchodilator in combination with an inhaled corticosteroid
☐ Yes	☐ No	Documentation* has been provided with this request of inadequate control of symptoms
☐ Yes	☐ No	Documentation* has been provided with this request showing the use of a long-acting bronchodilator in combination with an inhaled corticosteroid would be medically contraindicated
☐ Yes	☐ No	Patient has a history of at least one exacerbation in the past year requiring treatment with oral glucocorticoids
☐ Yes	☐ No	Patient is 18 years of age or older

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

9. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.