

SENTARA COMMUNITY PLAN (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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Please select drug below)

Preferred Medication (must be tried and failed FIRST)
<input type="checkbox"/> roflumilast (generic Daliresp [®])
Non-Preferred
<input type="checkbox"/> Daliresp[®] (roflumilast)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 1 year

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

AND

(Continued on next page)

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

AND

- ❑ Member has tried and failed generic roflumilast (Daliresp[®])

AND

- ❑ Adjunctive therapy (Daliresp[®] (roflumilast) **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.****