Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Daliresp (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Daliresp (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Daliresp (roflumilast)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the patient had a decrease in the number of COPD exacerbations since starting Daliresp? Y N

   [No further questions]

3. Does the patient have a diagnosis of severe COPD with chronic bronchitis? Y N

[If no, then no further questions.]

4. Did the patient have symptomatic COPD exacerbations within the last year? Y N

   [If no, then no further questions.]

5. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a 3 month trial of any of the following: A) a long-acting bronchodilator (LABA) plus a long-acting muscarinic antagonist (LAMA) plus an inhaled corticosteroid (ICS), B) a long-acting beta-agonist (LABA) plus an inhaled corticosteroid (ICS)? Y N

   If yes, list name(s) of products tried:
   _____

   [If no, then no further questions.]

6. Will the patient continue to use Daliresp with either of the following: A) a LABA (long-acting bronchodilator) PLUS a LAMA (long-acting muscarinic antagonist), B) a long-acting beta-agonist (LABA) PLUS an inhaled corticosteroid (ICS)? Y N

   [If yes, then skip to question 8.]

7. Has the patient had an intolerance or contraindication to the following: A) a LABA (long-acting beta-agonist) PLUS a LAMA (long-acting muscarinic antagonist), B) a LABA PLUS an ICS (inhaled corticosteroid)? Y N

   [If no, then no further questions.]

8. Does the patient have moderate to severe liver impairment (Child-Pugh B or C)? Y N

   [If yes, then no further questions]

9. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date