

DALIRESP Prior Authorization Form

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: DALIRESP	Strength: 500mcg Tablet	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Clinical Information

Diagnosis Code:	Date Diagnosed:
Does the member have a diagnosis of severe COPD (Gold stage III or IV)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have chronic bronchitis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a history of COPD exacerbation within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have moderate to severe liver impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a diagnosis of depression or on current treatment for depression? If yes, include documentation of an evaluation by a behavior health provider. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Chart documentation	

History of Medications Used to Treat Above Condition

- No other medications have been used to treat this condition

*Trial and failure of an inhaled long-acting beta agonist OR long-acting anticholinergic AND a glucocorticosteroid is req.

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below:
