Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (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 New Jersey at **1-855-296-0323**.
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 *(circle drug)*

Daliresp (roflumilast)

Other, specify drug _____

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:** _____

Circle the appropriate answer for each question.

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

   [If no, then skip to question 3.]

2. Has the member had an improvement in the number of COPD (Chronic Obstructive Pulmonary Disease) exacerbations? Y N

   [No further questions]

3. Does the member have a diagnosis of severe Chronic Obstructive Pulmonary Disease (COPD) with chronic bronchitis? Y N

[If no, then no further questions.]

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

   [If no, then no further questions.]

5. Has the member experienced an inadequate treatment response, intolerance, or contraindication to a 3 month trial of one of the following: A) a long-acting beta-agonist (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), C) a long-acting beta-agonist (LABA) plus a long-acting muscarinic antagonist (LAMA)? Y N

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

   _____

   [If no, then no further questions.]

6. Will the member continue to use Daliresp with any of the following: A) a long-acting beta-agonist (LABA), B) a long-acting muscarinic antagonist (LAMA), C) a long-acting beta-agonist (LABA) plus an inhaled corticosteroid (ICS), D) long-acting beta-agonist (LABA) plus long-acting muscarinic antagonist (LAMA)? Y N

   [If yes, then skip to question 8.]

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

   [If no, then no further questions.]

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

   [If yes, then no further questions]

9. Is the member 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**