Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Daliresp® (roflumilast)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Drug/Dose/Directions:		

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of severe chronic obstructive pulmonary disease (COPD) **WITH EITHER**:
   - ☐ 2 or more exacerbations in the past year
   - ☐ One exacerbation requiring hospitalization within the past year
3. Member must currently be on and compliant with a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA) **OR** triple combination LABA/LAMA/inhaled corticosteroid (ICS) inhaler:
   - Combination LABA/LAMA: _____
   - Triple therapy combination LABA/LAMA/ICS: _____
4. Provider attests an ICS has been considered and has either been prescribed OR provider has determined an ICS would not be appropriate for the member: ☐ Yes ☐ No
5. Provider attests member does not have hepatic impairment (Child Pugh B or C): ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed: 500mcg daily (1 tablet per day)

Initial authorization will be granted for 1 year.

☐ CONTINUATION OF THERAPY

1. Member has been adherent to Daliresp®: ☐ Yes ☐ No
2. Member is still on, and compliant with, combination LABA/LAMA or triple combination LABA/LAMA/ICS inhaler: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose allowed: 500mcg daily (1 tablet per day)

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.