PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Daliresp - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Daliresp - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Daliresp (roflumilast)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Are the patient's symptoms improving with treatment? Y N _____

[Note: Clinical documentation must be submitted.]

	[No further questions.]	
3.	Is the patient 18 years of age or older?	Y N
	[If no, then no further questions.]	
4.	Does the patient have a documented diagnosis of severe chronic obstructive pulmonary disease (COPD) with chronic bronchitis?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
5.	Has the patient had at least 2 exacerbations in the last 6 months?	Y N
	[Note: This should be reflected through paid claims for oral corticosteroids or progress notes.]	
	[If no, then no further questions.]	
6.	Is there documentation to support the concurrent use of a long-acting bronchodilator (either anticholinergic or beta agonist)?	Y N
	[Note: Documentation must be submitted.] \ [Note: At minimum, there should be 5 paid claims for a bronchodilator within the last 6 months.]	
	[If no, then no further questions.]	
7.	Does the patient have moderate to severe liver impairment?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date