

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT PHOSPHODIESTERASE INHIBITORS FOR COPD PRIOR AUTHORIZATION REQUEST FORM



o Medication Name:

CareSource Pharmacy Prior Authorization Form P.O. Box 8738 Dayton, OH 45401-8738 Fax: (866) 930-0019

T D .				
Today's Date		Non-Urgent ∐	Urgent □	
Note: This form must	ha completed by the pr	escribing provider. Incomple	oto forms will be returned	
Note. This form must	be completed by the pro	escribing provider. Incompli	ste forms will be returned.	
Member's Name		D	ate of Birth	
Member's Indiana Medicaid	ID # 🗆 🗆 🗆 🗆			
Member's CareSource # □□		Prescriber's Name		
Prescriber's Indiana License	# 000000	Specialty		
Prescriber's NPI #		Office Contact		
Prescriber's Fax # □□□-□[Prescriber's Phone #		
Prescriber's Address		Date(s) of Service: Start Date:		
Diagnosis Description		Diagnosis Code		
I attest the information on thi	e form is accurate:			
i allest the information on the	s ioiii is accurate.			
Physician Signature:		Date:		
Requested Medication	Strength	Quantity	Directions for Use	
PA Requirements for DALI	RESP (roflumilast)			
 Does the member ha 	ve severe chronic obstruc	ctive pulmonary disease (COF	D) associated with chronic	
bronchitis? ☐ Yes	☐ No			
		ions (please include documen		
 Please list the memb Date: 		ed (and include documentation	n):	
Member is utilizing a	combination long-acting l	beta-agonist (LABA)/long-actir	ng muscarinic antagonist	
(LAMA)/inhaled cortion	costeroid (ICS) therapy fo	or at least 90 days in the past 1	120 days. ☐ Yes ☐ No	
Provide name of bror	nchodilator therapies triale	ed: Member Na	ame:	
 Medication Na 				
○ Dates of Trial ■ Start [: Date:			
• Stop [Date:			

0	Dates of Trial:
	■ Start Date:
	Start Date:Stop Date:
	- Stop Date.
	Madiation Name
0	
0	
	Start Date:
	Stop Date:
It mei	mber will not be utilizing LABA/LAMA/ICS adjunct therapy, please provide rationale:
Presc	criber attests that the member will continue to utilize appropriate adjunct therapy (LABA/LAMA/IC
while	on Daliresp (roflumilast) therapy. \square Yes \square No
	, hereby attest that member will continue on adjunct therapy while utili
	(roflumilast) therapy.
umcsp	(Tonumust) therapy.
roccrib	or Signaturo:
162CHD	er Signature:
o autiro:	
4 2 1 0 1 0 1 1 1 1 2 2 1 1 1 1 1 1 1 1 1	manta far OUTIIVAVDE (anaifantrina)
oquilo	ments for OHTUVAYRE (ensifentrine)
Does	the member have a diagnosis of COPD? \square Yes \square No
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Does Pleas Date: Pleas Date: Meml (LAM Ye Provii	the member have a diagnosis of COPD?

•	Prescriber attests that the member will continue to utilize appropriate adjunct therapy (LABA/LAMA/ICS) while on Ohtuvayre (ensifentrine) therapy. \square Yes \square No
I, _ Oh	, hereby attest that member will continue on adjunct therapy while utilizing tuvayre (ensifentrine) therapy.
Pro	escriber Signature:

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.

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