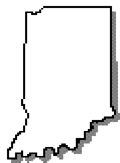
INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
PHOSPHODIESTERASE INHIBITORS FOR COPD PRIOR AUTHORIZATION REQUEST FORM



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

Today's Date ☐☐/☐☐/☐☐☐☐	Non-Urgent ☐	Urgent ☐

Note: This form must be completed by the prescribing provider. Incomplete forms will be returned.

Member's Name	Date of Birth ☐☐/☐☐/☐☐☐☐
Member's Indiana Medicaid ID # ☐☐☐☐☐☐☐☐	
Member's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Prescriber's Name
Prescriber's Indiana License # ☐☐☐☐☐☐☐☐	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 this form is accurate:

Physician Signature: ______________________________ **Date:** ___________________

Requested Medication	Strength	Quantity	Directions for Use

PA Requirements for DALIRESP (roflumilast)

- Does the member have severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis? ☐ Yes ☐ No
- Does the member have a history of exacerbations (please include documentation)? ☐ Yes ☐ No
- Please list the member's last FEV-1% predicted (and include documentation): _______________________ Date: _____________________
- Member is utilizing a combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days. ☐ Yes ☐ No

Member Name: _______________________

Provide name of bronchodilator therapies trialed:

- Medication Name: ________________________
- Dates of Trial:
  - Start Date: _____________
  - Stop Date: _____________
- Medication Name: ________________________

- Dates of Trial:
  - Start Date: ______________
  - Stop Date: ______________

- Medication Name: _________________________
- Dates of Trial:
  - Start Date: ______________
  - Stop Date: ______________

- If member will not be utilizing LABA/LAMA/ICS adjunct therapy, please provide rationale:
  ____
  ____
  ____

- Prescriber attests that the member will continue to utilize appropriate adjunct therapy (LABA/LAMA/ICS) while on Daliresp (roflumilast) therapy. ☐ Yes ☐ No

I, ________________________, hereby attest that member will continue on adjunct therapy while utilizing Daliresp (roflumilast) therapy.

Prescriber Signature: ____

PA Requirements for OHTUVAYRE (ensifentrine)

- Does the member have a diagnosis of COPD? ☐ Yes ☐ No
- Please list last FEV-1/FVC ratio (and include documentation): ______________________________
  Date: _______________

- Please provide last mMRC score (include documentation): _________________________________
  Date: _______________

- Member is utilizing combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days

  ☐ Yes ☐ No

  Provide name of bronchodilator therapies trialed:
  - Medication Name: _________________________
  - Dates of Trial:
    - Start Date: ______________
    - Stop Date: ______________

  - Medication Name: _________________________
  - Dates of Trial:
    - Start Date: ______________
    - Stop Date: ______________

  - Medication Name: _________________________
  - Dates of Trial:
    - Start Date: ______________
    - Stop Date: ______________

- If member will not be utilizing LABA/LAMA/ICS adjunct therapy, please provide rationale:
  ____

____

____

- Prescriber attests that the member will continue to utilize appropriate adjunct therapy (LABA/LAMA/ICS) while on Ohtuvayre (ensifentrine) therapy. ☐ Yes ☐ No

I, ______________________, hereby attest that member will continue on adjunct therapy while utilizing Ohtuvayre (ensifentrine) therapy.

Prescriber 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.**