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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Daliresp[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Moderate to very severe chronic obstructive pulmonary disease (COPD)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Chronic obstructive pulmonary disease:</p> <p>Is the patient's COPD associated with chronic bronchitis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a history of COPD exacerbations which required the use of systemic corticosteroids, antibiotics, or hospital admission? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a trial and failure, contraindication, or intolerance to two prior therapies for COPD? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Reauthorization. If this is a reauthorization request, answer the following:</p> <p>Is there documentation of positive clinical response to Daliresp therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Quantity limit requests:</p> <p>What is the quantity requested per DAY? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <p><input type="checkbox"/> Titration or loading-dose purposes</p> <p><input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> Other: _____</p>

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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 Office use only: Daliresp_Comm_2018Jun-W