UnitedHealthcare Community Plan

DALIRESP

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	**ICD 10 Code:**

Does the patient have a diagnosis of severe COPD? YES or NO (Circle Response)

Enter patient's FEV_1 or FEV_1/FVC: _____ *(Must include FEV_1 or FEV_1/FVC for request to be reviewed)*

Is the patient's COPD associated with chronic bronchitis, emphysema, or both? _____

Does the patient currently smoke or has a history of smoking? YES or NO (Circle Response)

Has the patient had a COPD exacerbation in the last year? YES or NO (Circle Response)
Date and description of exacerbation: _____

Drug Class (Examples)	Has the Patient tried?	Dates of Trial	Outcome
Inhaled anticholinergic (e.g. ipratropium, Combivent, Spiriva)			
Long acting beta agonist (e.g. Serevent, Foradil, Brovana)			
Short acting beta2 agonist (e.g. Ventolin HFA, Proventil HFA, ProAir)			
Inhaled Corticosteroid (e.g. Flovent, Qvar, Asmanex, Pulmicort)			

FOR CONTINUATION OF THERAPY: Has documentation been submitted showing the clinical benefit of Daliresp therapy? YES or NO (Circle Response) Describe benefit of therapy: _____

FOR REQUESTS FOR DOSES > 500 MCG DAILY: Is there a reason why a greater quantity of medication is required to treat the patient's condition? YES or NO (Circle Response) If yes explain: _____

Physician Signature: _____ **Date:** _____