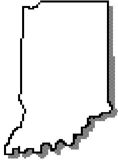
INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
PHOSPHODIESTERASE INHIBITORS FOR COPD PRIOR AUTHORIZATION REQUEST FORM



MDwise
Fax to: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131
Phone: (808) 788-2949

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

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 history of exacerbations (please include documentation) ☐ Yes ☐ No
- Please list member's last FEV-1 % predicted (and 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:_____________________________

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- 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 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).

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 (please 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 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)

Prescriber Signature: ____

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