

COPD AGENTS PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for COPD Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **COPD Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>). These agents are also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:			
<i>(*Requests for Daliresp – please use "Daliresp" prior authorization form)</i>			
<input type="checkbox"/> Anoro Ellipta	<input type="checkbox"/> Seebri Neohaler	<input type="checkbox"/> Stiolto Resipimat	
<input type="checkbox"/> Incruse Ellipta	<input type="checkbox"/> Spiriva Respimat	<input type="checkbox"/> Utibron Neohaler	
Directions:		Quantity:	Refills:
Diagnosis:		Diagnosis code (required):	

SECTION A: COPD DIAGNOSIS

1. Has the Recipient tried and failed the preferred COPD Agents?		<input type="checkbox"/> Yes	<i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i>
<input type="checkbox"/> Atrovent HFA <input type="checkbox"/> ipratropium nebs <input type="checkbox"/> Spiriva Handihaler <input type="checkbox"/> Combivent Respimat <input type="checkbox"/> ipratropium/albuterol nebs <input type="checkbox"/> Tudorza Pressair		<input type="checkbox"/> No	
2. Does the Recipient have a contraindication or intolerance to any of the preferred COPD Agents listed in question (1)?		<input type="checkbox"/> Yes	<i>Submit medical record documentation of contraindications/intolerances</i>
		<input type="checkbox"/> No	

SECTION B: ASTHMA DIAGNOSIS

1. Is this request for a tiotropium-containing agent?		<input type="checkbox"/> Yes	<i>submit medical literature supporting the use of the requested agent for the treatment of asthma</i>
		<input type="checkbox"/> No	
2. Is the Recipient 12 years of age or older?		<input type="checkbox"/> Yes	
		<input type="checkbox"/> No	
3. Is the Recipient currently receiving optimally titrated doses of both of the following?		<input type="checkbox"/> Yes	<i>Submit medical record documentation of Recipient's medication regimen and response to treatment</i>
<input type="checkbox"/> inhaled glucocorticoid <input type="checkbox"/> long-acting beta-agonist (LABA)		<input type="checkbox"/> No	
4. Does the Recipient have a contraindication or intolerance to optimally titrated doses of both of the following?		<input type="checkbox"/> Yes	<i>Submit medical record documentation of contraindications/intolerances</i>
<input type="checkbox"/> inhaled glucocorticoid <input type="checkbox"/> long-acting beta-agonist (LABA)		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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