West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Roflumilast (Daliresp®) Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Is the patient forty (40) years of age or older?	☐ Yes	☐ No - not approved
Does the patient have a diagnosis of severe chronic obstructive pulmonary disease (COPD)?	☐ Yes	☐ No - not approved
Has the patient had multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months?	☐ Yes - detail below	☐ No - not approved
Date and systemic steroids given:		
Is the patient compliant with an inhaled corticosteroid and long-acting bronchodilator?	☐ Yes - detail below	☐ No - not approved
List the inhaled steroid and bronchodilator the patient is using:		
Is there any evidence of moderate to severe liver impairment (Child-Pugh class B or C)?	☐ Yes -not approved	☐ No
Is the patient currently using any medications that are strong cytochrome P450 inhibitors (rifampicin, phnebarbital, carbamazepine or phenytoin)?	☐ Yes - not approved	☐ No

Other Pertinent Information.

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)