CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
DALIRESP® PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

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

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

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____

Drug Name	Strength	Quantity	Directions for Use

I attest that the provided information above is accurate:

Physician Signature:_____ **Date:** _____

PA Requirements for DALIRESP:

Does the member have severe COPD associated with chronic bronchitis? ☐ Yes ☐ No

Diagnosis Code: _____

Does the member have a history of exacerbations? ☐ Yes ☐ No

List last FEV-1% predicted: _____ Date:_____

Provide documentation to show member is inadequately controlled on long-acting beta agonist (e.g. Brovana, Foradil, Perforomist, Serevent), long-acting muscarinic antagonists (e.g. Spiriva), or combination bronchodilator therapy (e.g. Advair, Dulera, Symbicort). Complete table below and attach supporting documentation:

Drug Name	Strength	Dates of Use	Reason Treatment Failed