



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Daliresp<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>Continuation of therapy:</b>            Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No            If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <hr/>

<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Treatment to reduce the risk of chronic obstructive pulmonary disease (COPD) exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
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<p><b>Select the medication(s) the patient has had prior use of or are contraindicated, inappropriate, or ineffective:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Advair Diskus</td> <td style="width: 50%; padding: 5px;"><input type="checkbox"/> Budesonide suspension</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Advair HFA</td> <td style="padding: 5px;"><input type="checkbox"/> Dulera</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Aerospan</td> <td style="padding: 5px;"><input type="checkbox"/> Flovent Diskus</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Alvesco</td> <td style="padding: 5px;"><input type="checkbox"/> Flovent HFA</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Anoro Ellipta</td> <td style="padding: 5px;"><input type="checkbox"/> Foradil</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Arnuity Ellipta</td> <td style="padding: 5px;"><input type="checkbox"/> Qvar</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Asmanex HFA</td> <td style="padding: 5px;"><input type="checkbox"/> Serevent</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Asmanex Twisthaler</td> <td style="padding: 5px;"><input type="checkbox"/> Spiriva</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Atrovent</td> <td style="padding: 5px;"><input type="checkbox"/> Symbicort</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Breo Ellipta</td> <td></td> </tr> </table>	<input type="checkbox"/> Advair Diskus	<input type="checkbox"/> Budesonide suspension	<input type="checkbox"/> Advair HFA	<input type="checkbox"/> Dulera	<input type="checkbox"/> Aerospan	<input type="checkbox"/> Flovent Diskus	<input type="checkbox"/> Alvesco	<input type="checkbox"/> Flovent HFA	<input type="checkbox"/> Anoro Ellipta	<input type="checkbox"/> Foradil	<input type="checkbox"/> Arnuity Ellipta	<input type="checkbox"/> Qvar	<input type="checkbox"/> Asmanex HFA	<input type="checkbox"/> Serevent	<input type="checkbox"/> Asmanex Twisthaler	<input type="checkbox"/> Spiriva	<input type="checkbox"/> Atrovent	<input type="checkbox"/> Symbicort	<input type="checkbox"/> Breo Ellipta	
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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