Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Chronic Obstructive Pulmonary Disease (COPD) Agent

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the product being requested?

☐ Dupixent (dupilumab)
☐ Daliresp (roflumilast)
☐ Ohtuvayre (ensifentrine)
☐ Non-preferred COPD Agents
☐ PDE3 or PDE4 Inhibitor
☐ Other

Q3. If other, please specify:

Q4. For Daliresp, does the member have a diagnosis of severe COPD as documented by medical history, physical exam findings, and lung function testing that are consistent with severe COPD according to the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) COPD guidelines?

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☐ Yes ☐ No

Q5. Does the member have a diagnosis of chronic bronchitis as documented by cough and sputum production for at least three months in each of two consecutive years?

☐ Yes ☐ No

Q6. Have other causes of the member's chronic airflow limitations been excluded?

☐ Yes ☐ No

Q7. Does the member have a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) according to current GOLD COPD guidelines?

☐ Yes ☐ No

Q8. For the product Daliresp, does the member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q9. For the product Daliresp, does the member have suicidal ideations?

☐ Yes ☐ No

Q10. For a member with a history of suicide attempt, bipolar disorder, major depressive disorder, schizophrenia, substance use disorder, anxiety disorder, borderline personality disorder, or antisocial personality disorder, was the member evaluated, treated, and determined to be a candidate for treatment with the requested drug by a psychiatrist?

☐ Yes ☐ No

Q11. For all other members, had a mental health evaluation been performed by the prescriber and determined to be a candidate for treatment with the requested drug?

☐ Yes ☐ No

Q12. Has the member had a documented decrease in the frequency of COPD exacerbations?

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☐ Yes	☐ No
Q13. For the product Daliresp, does the member have a contraindication to the prescribed drug?	
☐ Yes	☐ No
Q14. For the product Daliresp, does the member have suicidal ideations?	
☐ Yes	☐ No
Q15. Was the member reevaluated and treated for new onset or worsening symptoms of anxiety and depression and determined to continue to be a candidate for treatment with the requested drug?	
☐ Yes	☐ No
Q16. For Ohtuvayre, does the member have a diagnosis of moderate to severe COPD as documented by medical history, physical exam findings, and lung function testing that are consistent with moderate to severe COPD according to the current GOLD COPD guidelines?	
☐ Yes	☐ No
Q17. Does the member have a score of greater than or equal to 2 on the Modified Medical Research Council (mMRC) Dyspnea Scale?	
☐ Yes	☐ No
Q18. Have other causes of the member's chronic airflow limitations been excluded?	
☐ Yes	☐ No
Q19. Does the member have a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) according to current GOLD COPD guidelines?	
☐ Yes	☐ No

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Member Name:	Prescriber Name:

Q20. For the product Ohtuvayre, does the member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q21. For the product Ohtuvayre, does the member have suicidal ideations?

☐ Yes ☐ No

Q22. For a member with a history of suicide attempt, bipolar disorder, major depressive disorder, schizophrenia, substance use disorder, anxiety disorder, borderline personality disorder, or antisocial personality disorder, was the member evaluated, treated, and determined to be a candidate for treatment with the requested drug by a psychiatrist?

☐ Yes ☐ No

Q23. Is there documentation of a positive clinical response to the prescribed drug (i.e., increased pulmonary function, decrease in the severity of dyspnea, decrease in the use of rescue medications, or decreased symptom severity)?

☐ Yes ☐ No

Q24. For the product Ohtuvayre, does the member have a contraindication to the prescribed drug?

☐ Yes ☐ No

Q25. For the product Ohtuvayre, does the member have suicidal ideations?

☐ Yes ☐ No

Q26. Was the member reevaluated and treated for new onset or worsening symptoms of anxiety and depression and determined to continue to be a candidate for treatment with the requested drug?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q27. Does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred COPD Agents?

☐ Yes ☐ No

Q28. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06