PHOSPHODIESTERASE INHIBITORS FOR PULMONARY-RELATED DISORDERS PRIOR AUTHORIZATION REQUEST FORM

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Optum Rx®
United Healthcare Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

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

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA Requirements for DALIRESP (roflumilast)

- Does the member have severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis? ☐ Yes ☐ No
- Does the member have history of exacerbations (please include documentation) ☐ Yes ☐ No
- Please list member's last FEV-1 % predicted (and include documentation): _____ Date:_____
- Member is utilizing combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days ☐ Yes ☐ No

  Provide name of bronchodilator therapies trialed:

  - Medication name:_____
  - Dates of trial:
    - Start date:_____
    - Stop date:_____

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- Dates of trial:
  - Start date:_____
  - Stop date:_____

- If member will not be utilizing LABA/LAMA/ICS adjunct therapy, please provide rationale:

  _____

  _____

  _____

- Prescriber attests that member will continue to utilize appropriate adjunct therapy (LABA/LAMA/ICS) while on Daliresp (roflumilast) therapy ☐ Yes ☐ No

I, _____hereby attest that member will continue on adjunct therapy while utilizing Daliresp (roflumilast).

Prescriber Signature: _____

PA Requirements for JASCAYD (nerandomilast)

Initial Authorization

- Select one of the following:
  - Diagnosis of idiopathic pulmonary fibrosis confirmed by lung biopsy or high-resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP) or probable UIP HRCT pattern (documentation must be submitted) ☐ Yes ☐ No
  - Diagnosis of progressive pulmonary fibrosis confirmed by consistent decline in lung function (supported by documentation such as HCRT scan, pulmonary function tests (PFTs), etc.) ☐ Yes ☐ No
- Member is 18 years of age or older ☐ Yes ☐ No
- Member has a forced vital capacity (FVC) greater than or equal to 45% of predicted at baseline (supported by submitted chart documentation) ☐ Yes ☐ No

- Member has a carbon monoxide diffusing capacity greater than or equal to 25% of predicted (supported by submitted chart documentation) ☐ Yes ☐ No
- Prescribed by, or in consultation with, a pulmonologist ☐ Yes ☐ No
- Requested dose does not exceed 18 mg twice daily ☐ Yes ☐ No

Reauthorization

- History of the requested agent for at least 90 days within the past 120 days, as confirmed by claims history, chart documentation, or provider attestation including dates of trial ☐ Yes ☐ No
- Member demonstrates positive clinical response to therapy (e.g., improvement/stabilization in FVC – documentation must be submitted to show trend from baseline) ☐ Yes ☐ No
- Requested dose does not exceed 18 mg twice daily ☐ Yes ☐ No

PA Requirements for OHTUVAYRE (ensifentrine)

- Does the member have a diagnosis of COPD? ☐ Yes ☐ No
- Please list last FEV-1/FVC ratio (and include documentation): _____
  Date:_____
- Please provide last mMRC score (please include documentation): _____
  Date:_____
- Member is utilizing combination long-acting beta-agonist (LABA)/long-acting muscarinic antagonist (LAMA)/inhaled corticosteroid (ICS) therapy for at least 90 days in the past 120 days ☐ Yes ☐ No

  Provide name of bronchodilator therapies trialed:

  - Medication name:_____
  - Dates of trial:
    - Start date:_____
    - Stop date:_____
  - Medication name:_____
  - Dates of trial:
    - Start date:_____
    - Stop date:_____
  - Medication name:_____
  - Dates of trial:
    - Start date:_____
    - Stop date:_____

- If member will not be utilizing LABA/LAMA/ICS adjunct therapy, please provide rationale:

  _____

  _____

  _____

- Prescriber attests that member will continue to utilize appropriate adjunct therapy (LABA/LAMA/ICS) while on Ohtuvayre (ensifentrine) therapy ☐ Yes ☐ No

I, _____hereby attest that member will continue on adjunct therapy while utilizing Ohtuvayre (ensifentrine)

Prescriber Signature: _____