Daliresp

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-396-4139 FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**	
Provider First Name:	**Provider Last Name:**	
Provider Phone:	**Provider Fax:**	**Provider NPI #:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	❑Yes ❑No

Diagnosis:

MEDICAL HISTORY

Does the member have a diagnosis of severe COPD (Gold stage III or IV)?	☐ Yes ☐ No
Does the member have chronic bronchitis?	☐ Yes ☐ No
Does the member have a history of COPD exacerbation within the past year?	☐ Yes ☐ No
Does the member have severe liver impairment?	☐ Yes ☐ No
Does the member have a diagnosis of depression or on current treatment for depression?	☐ Yes ☐ No

If yes, Please include documentation of an evaluation by a behavior health provider.

❑ **Chart documentation enclosed**

Please list all medications the member has previously tried and failed or is currently using.

Medication Name	Strength	Frequency	Dates of Trial		List adverse reactions/side effects/reason for discontinuation
			Start Date	End Date	

Please provide any additional information which should be considered in the space below: