Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COPD AGENTS PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

Prior authorization guidelines for **COPD Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐New request ☐Renewal request # of pages: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:
Directions for use:	Quantity:	Duration requested:
Diagnosis:		Dx code *(required)*:

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a PHOSPHODIESTERASE (PDE) INHIBITOR (e.g., Daliresp, Ohtuvayre):

☐**For DALIRESP (roflumilast):**
- ☐Has COPD that is severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
- ☐Has chronic bronchitis with cough and sputum production for at least 3 months per year in 2 consecutive years
- ☐Does not have moderate or severe liver impairment (Child-Pugh B or C) [contraindication]

☐**For OHTUVAYRE (ensifentrine):**
- ☐Has COPD that is moderate to severe according to current GOLD guidelines and based on medical history, physical exam findings, and lung function tests
- ☐Has a score of ≥2 on the Modified Medical Research Council (mMRC) Dyspnea Scale

☐**For ALL PDE inhibitors:**
- ☐Other causes of chronic airflow limitations have been excluded, such as asthma, bronchiectasis, heart failure, tuberculosis, etc.
- ☐Tried and failed or has a contraindication or an intolerance to first-line therapies according to current GOLD guidelines:
  - ☐Inhaled long-acting beta 2 agonist (LABA)
  - ☐Inhaled long-acting anticholinergic/muscarinic antagonist (LAMA)
  - ☐Inhaled corticosteroid (unless beneficiary has an eosinophil count <100 cells/microliter – *submit documentation of lab results*)
  - ☐other:

  _____
- ☐Does not have suicidal ideations
- ☐**For a beneficiary with a history of suicide attempt(s), bipolar disorder, major depressive disorder, schizophrenia,**

substance use disorder(s), anxiety disorder(s), borderline personality disorder, and/or antisocial personality disorder:

- ☐ Was evaluated and treated for this/these mental health condition(s) by a psychiatrist
- ☐ Is a candidate for treatment with the requested PDE inhibitor as determined by a psychiatrist

☐ **For a beneficiary who does not have a history of the above mental health conditions:**

- ☐ Had a mental health evaluation performed by the prescriber
- ☐ Is a candidate for treatment with the requested PDE inhibitor

2. For all OTHER COPD Agents:

☐ Tried and failed or has a contraindication or an intolerance to the preferred COPD Agents (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. For a PHOSPHODIESTERASE (PDE) INHIBITOR (e.g., Daliresp, Ohtuvayre):

☐ **For DALIRESP (roflumilast):**

- ☐ Frequency of COPD exacerbations has decreased since starting Daliresp
- ☐ Does not have moderate or severe liver impairment (Child-Pugh B or C) [contraindication]

☐ **For OHTUVAYRE (ensifentrine):**

- ☐ Experienced a positive clinical response to Ohtuvayre as documented by:
  - ☐ Increased pulmonary function
  - ☐ Decreased dyspnea severity
  - ☐ Decreased use of rescue drugs
  - ☐ Decreased symptom severity

☐ **For ALL PDE inhibitors:**

- ☐ Does not have suicidal ideations
- ☐ Was evaluated for new onset or worsening symptoms of anxiety and depression
- ☐ Is a candidate for treatment with the requested PDE inhibitor

2. For all OTHER COPD Agents → complete beneficiary, prescriber, and drug fields at the top of this form and submit request with recent chart notes to DHS

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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