

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
DALIRESP PRIOR AUTHORIZATION REQUEST FORM**



Pharmacy Benefit Management (PBM) Call Center
4550 Victory Lane
Indianapolis, IN 46203
Phone: (866) 879-0106 Fax: (866) 780-2198



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

Today's Date

□□ / □□ / □□□□

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 #	□□□ - □□□ - □□□□□

Please confirm the following for Daliresp authorization:

- Patient has severe COPD associated with chronic bronchitis**
 Yes No
- Patient has a history of exacerbations**
 Yes No
- Please list last FEV-1:** _____

Please provide additional information to show patient is inadequately controlled on bronchodilator therapy.

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