



# Nevada Medicaid – Molina Healthcare

## Daliresp® Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Molina ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical information:</b>	
Does the member have a history of COPD exacerbations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a diagnosis of moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the member experienced an inadequate response, adverse event, or contraindication to a long-acting anticholinergic agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please document agent and response: _____	
Has the member experienced an inadequate response, adverse event, or contraindication to a long-acting beta agonist? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please document agent and response: _____	
Has the member experienced an inadequate response, adverse event, or contraindication to an inhaled corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please document agent and response: _____	

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call (833) 685-2103.  
This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**