Pharmacy Drug Policy & Procedure

Policy Name:	Daliresp (roflumilast)	Policy #:	1819P

Purpose of the Policy

The purpose of this policy is to establish the prior authorization criteria for Daliresp and roflumilast.

Statement of the Policy

Health Alliance Medical Plans will approve the use of Daliresp or roflumilast when the following criteria have been met.

Criteria

1. **Coverage Criteria**
   - 1.1 Documented diagnosis of chronic obstructive pulmonary disease (COPD)
   - 1.2 Documented failure on triple inhaler therapy (inhaled corticosteroid (ICS), long acting muscarinic antagonist (LAMA), long acting beta2 agonist (LABA)) as supported by the GOLD Guidelines
2. **Approval Period**
   - 2.1 Initial: 12 months
   - 2.2 Reauthorization: 12 months with documented clinical benefit

CPT Codes

HCPCS Codes

References

1. Daliresp (roflumilast) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; March 2020.
2. Sharma M, Joshi S, Banjade P, et al. Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2023 Guidelines Reviewed. Open Respir Med J. 2024 Jan 10;18:e18743064279064.

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DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.