

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
TIOTROPIUM BROMIDE (SPIRIVA®)
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #: _____	Patient Name: _____	DOB: _____
Patient Address: _____		
Iowa Medicaid Provider Number: _____	Prescriber Name: _____	Phone: _____
Prescriber Address: _____		Fax: _____
Pharmacy Name: _____	Address: _____	Phone: _____
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.		
Pharmacy IA Medicaid Provider #: _____	Pharmacy Fax: _____	NDC : _____

Prior authorization is required for Spiriva®. Payment will be authorized for patients who meet all the following criteria:
Diagnosis of mild, moderate or severe Chronic Obstructive Pulmonary Disease, symptomatic with documented pulmonary test showing obstruction, treatment failure or compliance failure with ipratropium therapy, regularly scheduled ipratropium therapy is discontinued when Spiriva® therapy begins.

Non-Preferred

Spiriva

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- Chronic Obstructive Pulmonary disease (COPD) according to the GOLD criteria:**
 - Mild – FEV₁ ≥ 80 % FEV₁/FVC < 70 %
 - Moderate – FEV₁ 30% - 79 % FEV₁/FVC < 70%
 - Severe – FEV₁ < 30% FEV₁/FVC < 70%
- Other (specify):** _____

Is patient symptomatic? Yes No

Pulmonary test documenting obstruction: _____ Date of test: _____

Treatment failure or compliance failure with ipratropium therapy: Trial Drug Name: _____

Trial start date: _____ Trial end date: _____ Reason for failure: _____

NOTE: Regularly scheduled ipratropium therapy is discontinued when Spiriva® therapy begins.

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.