

Ofev (nintedanib)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page



Ofev (nintedanib)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?		
<input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Idiopathic pulmonary fibrosis (IPF) <input type="checkbox"/> Systemic sclerosis(SSc)-associated interstitial lung disease <input type="checkbox"/> Fibrosing interstitial lung disease(Excluding IPF) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No Is prescriber a pulmonologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient used Esbriet (pirfenidone)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have an absolute contraindication to pirfenidone(Esbriet)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Ofev (nintedanib) be used concurrently with Esbriet (pirfenidone) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Ofev (nintedanib) be used concurrently with Jascayd® (nerandomilast) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No For <u>diagnosis of Idiopathic pulmonary fibrosis (IPF)</u> , answer the following: Is high resolution CT of the chest consistent with a diagnosis of idiopathic pulmonary fibrosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (Please submit imaging report.) Is the patient's forced vital capacity (FVC) ≥ 50% of the predicted value?* <input type="checkbox"/> Yes <input type="checkbox"/> No *Please provide supporting documentation including a pulmonary function test (PFT) report and/or chart notes. Is the patient's carbon monoxide (CO) diffusing capacity 30-79% of the predicted value?* <input type="checkbox"/> Yes <input type="checkbox"/> No No <input type="checkbox"/> *Please provide supporting documentation including a pulmonary function test (PFT) report and/or chart notes. For <u>diagnosis of Systemic sclerosis (SSc)-associated interstitial lung disease</u> , answer the following: Does the patient's systemic sclerosis meet the current ACR/EULAR criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit rheumatologist report.		



Ofev (nintedanib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Is the diagnosis of systemic sclerosis(SSc)-associated interstitial lung disease confirmed by chest CT? Yes No

Does the confirmatory chest CT show fibrosis affecting at least 10% of the lungs? Yes No
Please submit imaging report.

Does patient have a FVC greater than or equal to 40% predicted? Yes No
Please submit PFT report and/or chart notes.

Is patient's CO diffusing capacity 30-89% predicted? Yes No
Please submit PFT report and/or chart notes.

For diagnosis of fibrosing interstitial lung disease, answer the following:

Does the patient have a diagnosis of idiopathic pulmonary fibrosis? Yes No

Does the patient's corrected carbon monoxide diffusion capacity (DLCOc) equal at least 30% and less than 80% predicted of normal? Yes No *Please submit PFT or spirometry results.*

Does the patient's forced vital capacity (FVC) % predicted equal at least 45% predicted? Yes No
Please submit PFT or spirometry results.

Did the patient's FVC % predicted experience a relative decline of at least 10% in the past 24 months? Yes No *Please submit PFT or spirometry results.*

In the past 24 months, did the patient's FVC % predicted experience a relative decline greater than 5% and less than 10%? Yes No *Please submit PFT or spirometry results.*

In the past 24 months, did the patient have documented worsening of respiratory symptoms? Yes No

Please submit PFT or spirometry results.

In the past 24 months, did the patient have a documented increase in the extent of fibrotic changes on chest imaging compared to prior studies? Yes No *Please submit imaging report documenting the interval change*

Does the fibrosing lung disease have disease extent of greater than 10% as documented on high resolution CT?

Yes No *Please submit an imaging report from the previous 12 months.*

Does the patient have pulmonary arterial hypertension? Yes No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

Ofev (nintedanib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909