Ofev (nintedanib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Idiopathic pulmonary fibrosis (IPF) □ Systemic sclerosis(SSc)-associated interstitial lung disease □ Fibrosing interstitial lung disease(Excluding IPF) □ Other diagnosis: _____ICD-10: _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

For <u>diagnosis of Idiopathic pulmonary fibrosis (IPF)</u>, answer the following:

Has the patient used Esbriet (pirfenidone) in the previous 8 weeks? □ Yes □ No

Will Ofev (nintedanib) be used concurrently with Esbriet (pirfenidone) therapy? □ Yes □ No

Is high resolution CT of the chest consistent with a diagnosis of idiopathic pulmonary fibrosis? □ Yes □ No
(Please submit imaging report.)

Is the patient's forced vital capacity (FVC) ≥ 50% of the predicted value?* □ Yes □ 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?* □ Yes □ No
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? □ Yes □ No
Please submit rheumatologist report.

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.

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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.*

Has patient received prior treatment with either nintedanib (Ofev®) or pirfenidone (Esbriet®)? □ Yes □ No *Please submit documentation.*

Has the patient received any of the following medications in the previous month: azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, oral corticosteroids with daily dose greater than 20mg, cyclophosphamide or rituximab? □ Yes □ No

Does the patient have pulmonary arterial hypertension? □ Yes □ No

Has the patient had a myocardial infarction OR unstable cardiac angina in the past 6 months? □ 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.

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:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811