Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Ofev® (nintedanib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Ofev 100 mg capsule ☐ Ofev 150 mg capsule

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Ofev coverage is limited to 2 capsules daily

Drug cost information

The wholesale acquisition cost for each capsule is $133.34. The annual cost of treatment with this drug will be about $96,000.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (provide supporting documentation):

1. Age 18 years or greater
2. Current non-smoker
3. Prescribed by, or in consultation with, a pulmonologist
4. Must have idiopathic pulmonary fibrosis
    a. Prescriber must rule out: other known causes of interstitial lung disease, AND
    b. Must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy; and possibly surgical lung biopsy

For continuation of previously authorized coverage, the patient must meet all the following requirements:

1. Current non-smoker
2. Documentation of stable FVC (recommended to discontinue if there is a >10% decline in FVC over a 12 month period, indicating disease progression)
3. Adherence to treatment
4. Patient's liver function is being monitored regularly

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2018

Last reviewed 01/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New Request
Priority Health Precertification Documentation

A. Is the patient a current non-smoker?
☐ Yes ☐ No

B. What condition is this drug being requested for?
☐ Idiopathic pulmonary fibrosis
☐ *Other – the patient's condition is:* _____

C. Does the patient have a known cause of interstitial lung disease?
☐ Yes ☐ No

D. Does the patient's condition have presence of a UIP pattern on HRCT?
☐ Yes ☐ No

E. What is the patient's baseline FCV? _____ **Date** _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Is the patient a current non-smoker?
☐ Yes ☐ No

B. What is the patient's current FCV? _____ **Date** _____

C. Has the patient been compliant with treatment?
☐ Yes ☐ No

D. Are the patient's liver function tests being monitored regularly?
☐ Yes ☐ No

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