HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM OFEV®, pirfenidone

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date: Member Name: ID#:						
Office Phone: Office Phone: Office Fax: Office Contact: Height/Weight: Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: pirfenidone, Ofev® (nintedanib) Dosing/Frequency: If the request is for reauthorization, proceed to reauthorization section. Questions Yes No Comments/Notes 1. Does the member have one of the corresponding diagnoses: • pirfenidone: idiopathic pulmonary fibrosis: • Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease? 2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist? 3. Does the member have a carbon monoxide diffusing capacity Please provide documentation (%DLco) of 30-90% predicted? 4. Does the member have a carbon monoxide diffusing capacity Please provide documentation (%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? Please provide documentation computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? Please provide documentation tolerability of the therapy? 3. Does the member show a continued medical need and tolerability of the therapy? 3. Does documentation show current liver enzymes are within Please provide documentation	Date:	Member Name:		ID#:		
Height/Weight: HCPCS Code:	DOB: Gender:			Phy	Physician:	
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested:	Office Phone: Office Fax:			Offi	Office Contact:	
preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: pirfenidone, Ofev® (nintedanib) Dosing/Frequency: If the request is for reauthorization, proceed to reauthorization section. Questions Yes No Comments/Notes 1. Does the member have one of the corresponding diagnoses: Please provide documentation • pirfenidone: idiopathic pulmonary fibrosis or systemic sclerosis-associated interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease? 2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist? 3. Does the member have a forced vital capacity (%FVC) of > 50% Please provide documentation predicted? 4. Does the member have a carbon monoxide diffusing capacity Please provide documentation (%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? Please provide documentation computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? Please provide documentation tolerability of the therapy? 3. Does documentation show current liver enzymes are within Please provide documentation	Height/Weight:			НСР	HCPCS Code:	
Questions Yes No Comments/Notes 1. Does the member have one of the corresponding diagnoses:	preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: pirfenidone, Ofev® (nintedanib)					
1. Does the member have one of the corresponding diagnoses: • pirfenidone: idiopathic pulmonary fibrosis • Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease? 2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist? 3. Does the member have a forced vital capacity (%FVC) of > 50% predicted? 4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? Please provide documentation computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? Please provide documentation please provide do	If the request is for reauthorization, proceed to reauthorization section.					
• pirfenidone: idiopathic pulmonary fibrosis • Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease? 2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist? 3. Does the member have a forced vital capacity (%FVC) of > 50% predicted? 4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? Please provide documentation computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION Please provide documentation	·		Yes	No	Comments/Notes	
3. Does the member have a forced vital capacity (%FVC) of > 50% predicted? 4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? Please provide documentation computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? Please provide documentation please prov	 pirfenidone: idiopathic pulmona Ofev: chronic fibrosing interstiti progressive phenotype, idiopath systemic sclerosis-associated in Is the requesting prescriber a pulmona 	ary fibrosis ial lung disease with a hic pulmonary fibrosis, or terstitial lung disease?			Please provide documentation	
(%DLco) of 30-90% predicted? 5. Have recent liver function tests been performed? 6. Is the member's diagnosis confirmed by high-resolution computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION		al capacity (%FVC) of > 50%			Please provide documentation	
6. Is the member's diagnosis confirmed by high-resolution computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? 2. Does the member show a continued medical need and tolerability of the therapy? 3. Does documentation show current liver enzymes are within		onoxide diffusing capacity			Please provide documentation	
computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy? REAUTHORIZATION 1. Is the request for reauthorization of therapy? 2. Does the member show a continued medical need and tolerability of the therapy? 3. Does documentation show current liver enzymes are within Please provide documentation	5. Have recent liver function tests bee	n performed?			Please provide documentation	
 Is the request for reauthorization of therapy? Does the member show a continued medical need and tolerability of the therapy? Does documentation show current liver enzymes are within Please provide documentation Please provide documentation	computed tomography (HRCT) scan	, a bronchioaveolar lavage			Please provide documentation	
 Does the member show a continued medical need and tolerability of the therapy? Does documentation show current liver enzymes are within Please provide documentation Please provide documentation	REAUTHORIZATION					
tolerability of the therapy? 3. Does documentation show current liver enzymes are within Please provide documentation	1. Is the request for reauthorization of	f therapy?				
		d medical need and			Please provide documentation	
		liver enzymes are within			Please provide documentation	

What medications and/or treatment modalities have been tried in the past for this condition? Please document
name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

Policy PHARM-HU-091 Origination Date: 01/01/2022 Reviewed/Revised Date: 01/17/2024 Next Review Date: 01/17/2025 Current Effective Date: 02/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.