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#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

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?	☐	☐	**Please provide documentation**
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?	☐	☐	**Please provide documentation**
4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted?	☐	☐	**Please provide documentation**
5. Have recent liver function tests been performed?	☐	☐	**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?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a continued medical need and tolerability of the therapy?	☐	☐	**Please provide documentation**
3. Does documentation show current liver enzymes are within normal limits?	☐	☐	**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:

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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