

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM
ESBRIET[®], OFEV[®]

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

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: Esbriet[®] (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: <ul style="list-style-type: none"> • Esbriet: idiopathic pulmonary fibrosis • Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease? 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a forced vital capacity (%FVC) of > 50% predicted?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Have recent liver function tests been performed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is the member's diagnosis confirmed by high-resolution computed tomography (HRCT) scan, a bronchioalveolar lavage (BAL) and/or a surgical lung biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member show a continued medical need and tolerability of the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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3. Does documentation show current liver enzymes are within normal limits?	<input type="checkbox"/>	<input type="checkbox"/>	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-091
 Origination Date: 10/03/2019
 Reviewed/Revised Date: 10/28/2020
 Next Review Date: 10/28/2021
 Current Effective Date: 11/01/2020

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