

Prior Authorization
JOHNS HOPKINS HEALTH PLANS (MEDICAID) Ofev - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Ofev - Priority Partners MCO.

Drug Name (select from list of drugs shown) Ofev (nintedanib)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 17.]	

2. Is the requested medication being prescribed for idiopathic pulmonary fibrosis (IPF)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 5.]	
3. Has the patient's diagnosis of idiopathic pulmonary fibrosis (IPF) been confirmed by all of the following: A) exclusion of other known causes of interstitial lung disease, such as domestic and occupational environmental exposures, connective tissue disease, drug toxicity, etc., and B) high resolution computerized tomography (HRCT) pattern, and surgical lung biopsy (if available) findings consistent with a diagnosis of IPF?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Have all of the following been submitted: A) baseline liver function tests (LFTs) within normal limits, B) baseline forced vital capacity (FVC) greater than or equal to 50 percent of predicted, C) baseline carbon monoxide diffusing capacity (DLCO) 30 percent to 79 percent of predicted, and D) the patient has a low risk of any cardiovascular events?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 8.]	
[If no, no further questions.]	
5. Does the patient have a clinical diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, skip to question 9.]	
6. Have evidence of all of the following been submitted: A) high resolution computerized tomography (HRCT) confirmation of fibrosis (greater than 10 percent fibrotic features), AND B) signs of disease progression since diagnosis, defined as at least one of the following: 1. forced vital capacity (FVC) decline greater than or equal to 10 percent, 2. FVC decline less than 10 percent but greater than or equal to 5 percent with worsening symptoms or imaging, or 3. worsening symptoms and worsening imaging?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Have all of the following been submitted: A) baseline liver function tests (LFTs) within normal limits, B) baseline forced vital capacity (FVC) greater than or equal to 45 percent of predicted, C) baseline carbon monoxide diffusing capacity (DLCO) 30 percent to 79 percent of	<input type="checkbox"/> Y <input type="checkbox"/> N

predicted, and D) the patient has a low risk of any cardiovascular events?	
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Is the requested medication being prescribed by, or in consultation with, a pulmonologist?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 13.]	
[If no, no further questions.]	
9. Does the patient have a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Has the patient's diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) been confirmed by all of the following: A) high resolution computerized tomography (HRCT) confirmation of greater than or equal to 10 percent fibrosis, and B) clinical manifestations of disease, such as skin thickening of fingers of both hands, fingertip lesions, abnormal nail-fold capillaries, pulmonary arterial hypertension, Raynaud's phenomenon, or the presence of scleroderma-specific antibodies?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Have all of the following been submitted: A) baseline liver function tests (LFTs) within normal limits, B) baseline forced vital capacity (FVC) greater than or equal to 40 percent of predicted, C) baseline carbon monoxide diffusing capacity (DLCO) 30 percent to 89 percent of predicted, and D) the patient has a low risk of any cardiovascular events?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Is the requested medication being prescribed by, or in consultation with, a pulmonologist or rheumatologist?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
13. Is the patient a female and of childbearing age?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 15.]	
14. Does all of the following apply: A) verification of non-pregnant status prior to treatment initiation, and B) documentation that the patient will utilize two forms of birth control during treatment, and up to 3 months post-treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

15. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
16. Does any of the following exclusions apply to the patient: A) patient is a current smoker, B) patient has moderate or severe hepatic impairment, C) patient has history of previous myocardial infarction, stroke, intracranial bleeding, D) patient has a history of abdominal surgery, E) patient has a history of pathological bleeding disorders?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
17. Does all of the following apply: A) reduction in the annual rate of decline in forced vital capacity (FVC), and B) improvement of, or no worsening in, clinical symptoms?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date