Prior Authorization Request Form for
nerandomilast (Jascayd)

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires in 12 months. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely. *Usage for progressive pulmonary fibrosis is **not** approved at this time.*

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐Yes (subject to verification) Proceed to question **13**	☐No Proceed to question **2**
2. Provider acknowledges pirfenidone (Esbriet generic) is the Department of Defense's preferred drug for Idiopathic Pulmonary Fibrosis (IPF).	☐**Acknowledged** Proceed to question **3**	
3. Is the patient 18 years of age or older?	☐Yes Proceed to question **4**	☐No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by a pulmonologist?	☐Yes Proceed to question **5**	☐No **STOP** **Coverage not approved**
5. Is the patient a smoker?	☐Yes **STOP** **Coverage not approved**	☐No Proceed to question **6**
6. What is the indication or diagnosis?	☐ Documented idiopathic pulmonary fibrosis (IPF)– Proceed to question **7** ☐ Progressive pulmonary fibrosis - **STOP – Coverage not approved** ☐ Other diagnosis – **STOP – Coverage not approved**	

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7. Does the patient require nerandomilast (Jascayd) as add-on therapy OR monotherapy?	☐ Add-on therapy – Proceed to question **8** ☐ Monotherapy - Proceed to question **10**	
8. Has the patient tried and failed pirfenidone (Esbriet generic) due to progression of disease as defined as greater than 10% decline of forced vital capacity (FVC)?	☐ Yes Proceed to question **12**	☐ No Proceed to question **9**
9. **Has the patient tried and failed nintedanib (Ofev) due to progression of disease as defined as greater than 10% decline of forced vital capacity?**	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed pirfenidone (Esbriet generic) and experienced intolerable adverse effects (for example, rash, photosensitivity; GI adverse events) or is taking a drug that will interact with pirfenidone (Esbriet generic)?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Has the patient tried and failed nintedanib (Ofev) due to experiencing intolerable adverse effects (for example, rash, photosensitivity; GI adverse events) or is taking a drug that will interact with nintedanib (Ofev)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient receiving triple therapy with nerandomilast (Jascayd), pirfenidone (Esbriet, generics), and nintedanib (Ofev)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
13. Is the requested medication being prescribed by a pulmonologist?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has the patient shown clinical benefit with therapy?	☐ Yes - **Sign and date below** ☐ No – **STOP - Coverage not approved** ☐ Patient has not been established on therapy long enough to demonstrate clinical benefit - **please submit this request using the initial therapy pathway –** Proceed to question **2**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[18 March 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: