Prior Authorization Request Form for
nintedanib esylate (**Ofev**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

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 Ofev*	☐ Yes Proceed to question **14**	☐ No Proceed to question **2**
2. **Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis (IPF)?**	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. **Does the patient have a documented diagnosis of Systemic sclerosis-associated interstitial lung disease (SSc-ILD)?**	☐ Yes Proceed to question **11**	☐ No Proceed to question **4**
4. **Does the patient have a documented diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype?**	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
5. **Esbriet is the Department of Defense's preferred drug for Idiopathic Pulmonary Fibrosis. Has the patient tried Esbriet?**	☐ Yes Proceed to question **6**	☐ No Proceed to question **8**
6. **Has the patient failed therapy with Esbriet due to progression of IPF rate of decline of forced vital capacity (FVC) of greater than minus 10%?**	☐ Yes Proceed to question **11**	☐ No Proceed to question **7**
7. **Has the patient tried Esbriet and experienced intolerable adverse effects (for example rash, photosensitivity, GI adverse events)?**	☐ Yes Proceed to question **11**	☐ No Proceed to question **8**
8. **Is the patient taking a drug which will interact with Esbriet (for example moderate to strong CYP 1A2 inhibitors)?**	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. **Please provide the drug name which will interact with Esbriet.**	_____ Proceed to question **11**	

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10. Does the patient have ESRD AND is on dialysis?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient a smoker?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient being actively managed by a pulmonologist?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient also receiving therapy with Esbriet?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
14. Has the patient continued to refrain from smoking?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is this renewal being submitted by a pulmonologist?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the patient also receiving therapy with Esbriet?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. Has the patient experienced a significant reduction in the annual rate of decline of forced vital capacity (FVC)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[17 April 2020]

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