FAX Completed Form To
1-844-512-9004

Provider Help Desk
1-800-454-3730
https://providers.amerigroup.com

Request for Prior Authorization
IDIOPATHIC PULMONARY FIBROSIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for pirfenidone (Esbriet®) and nintedanib (Ofev®). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met:

1) **Patient is 40 years of age or older; and**
2) **Is prescribed by a pulmonologist; and**
3) **Patient has a diagnosis of idiopathic pulmonary fibrosis as confirmed by one of the following (attach documentation):**
   - **Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or**
   - **A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and**
4) **Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity; and**
5) **Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥ 50% predicted; and**
6) **Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted; and**
7) **Patient does not have hepatic impairment as defined below:**
   - **Nintedanib – Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C) or**
   - **Pifenidone – Patient does not have severe hepatic impairment (Child-Pugh C); and**
8) **Patient does not have renal impairment as defined below:**
   - **Nintedanib – Patient does not have severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease or**
   - **Pifenidone – Patient does not have end-stage renal disease requiring dialysis; and**
9) **Patient is a nonsmoker or has been abstinent from smoking for at least six weeks.**

If criteria for coverage are met, initial authorizations will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

- **Adherence to pirfenidone (Esbriet®) and nintedanib (Ofev®) is confirmed; and**
- **Patient is tolerating treatment defined as improvement or maintenance of disease (<10% decline in percent predicted FVC or < 200 mL decrease in FVC); and**
- **Documentation is provided that the patient has remained tobacco-free; and**
- **ALT, AST, and bilirubin are assessed periodically during therapy.**

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Non-Preferred

☐ Esbriet ☐ Ofev

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Is Prescriber a Pulmonologist? ☐ Yes ☐ No

Attach results of high-resolution computed tomography (HRCT) or surgical lung biopsy indicating usual interstitial pneumonia (UIP).

Has prescriber excluded other known causes of interstitial lung disease (ILD)? ☐ Yes ☐ No

Patient has pulmonary function test within the prior 60 days documenting a forced vital capacity (FVC) ≥ 50% predicted: ☐ Yes (attach results) ☐ No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted? ☐ Yes (attach results) ☐ No

Does patient have moderate to severe hepatic impairment? ☐ Yes, Child Pugh B ☐ Yes, Child Pugh C ☐ No

Does patient have moderate to severe renal impairment or end-stage renal disease? ☐ Yes ☐ No

CrCl:_____ Date obtained:_____ Is patient on dialysis? ☐ Yes ☐ No

Patient is a nonsmoker or has been abstinent from smoking for at least 6 weeks? ☐ Yes ☐ No

Renewal Requests:

Patient is adherent to therapy: ☐ Yes ☐ No

Patient has remained tobacco-free: ☐ Yes ☐ No

Patient is tolerating treatment defined as improvement or maintenance of disease (attach results):

☐ < 10% decline in percent predicted FVC or

☐ < 200 mL decrease in FVC

ALT, AST, and bilirubin are being assessed periodically: ☐ Yes ☐ No Most recent date obtained:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*

CASE NUMBER: 1623028