

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Jascayd[®] (nerandomilast)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage: 18 mg every 12 hours. If not tolerated, may decrease dose to 9 mg every 12 hours except in persons receiving concomitant pirfenidone.

Quantity Limit: 2 tablets per day (both strengths)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Idiopathic Pulmonary Fibrosis

Initial Authorization: 12 months

- Prescribed by or in consultation with a pulmonology specialist
- Member is 18 years of age or older

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- Member has a diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by **ALL** the following:
 - Excluding any other causes of interstitial lung disease (i.e. environmental exposure, drug toxicity, and connective tissue disease)
 - Current high-resolution computed tomography (HRCT) documents idiopathic fibrosis or probable IPF **OR** usual interstitial pneumonia (UIP)
 - If IPF is not definitive, a lung biopsy has also been done to confirm IPF/UIP
- For initiating therapy:
 - Member's forced vital capacity (FVC) is measured to be $\geq 45\%$ of the predicted value (**please provide current pulmonary function test (PFT) report results**)
 - Member's Diffusing Capacity (of Lung) for Carbon Monoxide (DLCO) $\geq 25\%$ of predicted normal corrected for hemoglobin (Hb) (**please provide current pulmonary function test (PFT) report results**)
- If prescribed in combination with nintedanib (OFEV[®]) or pirfenidone (Esbriet[®]), documentation supports inadequate response to monotherapy with nintedanib (OFEV[®]) or pirfenidone (Esbriet[®]) at up to maximally indicated doses (**please provide supporting documentation of unsuccessful trial(s) including PFT reports and/or chart notes**)

Diagnosis: Idiopathic Pulmonary Fibrosis

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member continues to meet diagnostic criteria in initial authorization section above
- Member's current state of disease and symptomology has been determined to be stable (**please provide current supporting documentation that the disease has responded by reduction in the rate of decline in forced vital capacity (%FVC) compared to pre-treatment baseline and/or reduction in the number of pulmonary fibrosis exacerbations from baseline**)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Diagnosis: Progressive Pulmonary Fibrosis

Initial Authorization: 12 months

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- Prescribed by or in consultation with a pulmonology specialist
- Member is 18 years of age or older
- Member has a diagnosis of progressive pulmonary fibrosis (PPF) confirmed by pulmonary fibrosis affecting more than 10% of lung volume on a high-resolution computed tomographic (CT) scan obtained within the last 12 months (**please provide HRCT scan results**)
- Member has at least **ONE** of the following (**please provide supporting documentation of criteria**):
 - A relative decline of at least 10% in the percentage of the predicted FVC
 - A relative decline of at least 5% but less than 10% in the percentage of the predicted FVC with worsened respiratory symptoms, an increased extent of fibrotic changes on imaging, or both
 - Worsened respiratory symptoms and an increased extent of fibrotic changes on imaging
- For initiating therapy:
 - Member's forced vital capacity (FVC) is measured to be $\geq 45\%$ of the predicted value (**please provide current pulmonary function test (PFT) report results**)
 - Member's Diffusing Capacity (of Lung) for Carbon Monoxide (DLCO) is $\geq 25\%$ of predicted normal corrected for hemoglobin (Hb) (**please provide current pulmonary function test (PFT) report results**)
- If prescribed in combination with nintedanib (OFEV[®]) or pirfenidone (Esbriet[®]), documentation supports inadequate response to monotherapy with nintedanib (OFEV[®]) or pirfenidone (Esbriet[®]) at up to maximally indicated doses (**please provide supporting documentation of unsuccessful trial(s) including PFT report and/or chart notes**)

Diagnosis: Progressive Pulmonary Fibrosis

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member continues to meet diagnostic criteria in initial authorization section above
- Members' current state of disease and symptomology has been determined to be stable (**please provide current supporting documentation that the disease has responded by reduction in the rate of decline in forced vital capacity (%FVC) compared to pre-treatment baseline and/or reduction in the number of pulmonary fibrosis exacerbations from baseline**)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****