AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **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 ≥ 45% of the predicted value **(please provide current pulmonary function test (PFT) report results)**
  - ❑ Member's Diffusing Capacity (of Lung) for Carbon Monoxide (DLCO) ≥ 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 ≥ 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 ≥ 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.**

***Approved by Pharmacy and Therapeutics Committee**: ~~11/20/2025,~~ **3/26/2026**
REVISED/UPDATED/REFORMATTED: ~~12/05/2025,~~ **4/16/2026**