# 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.**

## Interstitial Lung Disease Agents (Non-Preferred)

**Drug Requested**: (Check below the drug that applies)

| | |
|---|---|
| ❑ **Esbriet®** | ❑ **Ofev®** |

**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:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight:** _____ **Date:** _____

**CLINCIAL 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.

**Authorization Approval Length: 1 Year**

1. Is the medication being prescribed by a pulmonologist? ❑ Yes ❑ No

**AND**

2. Is the member 18 years of age or older? ❑ Yes ❑ No

**AND**

**(Continued on next page)**

3. For **OFEV®:** Does the patient have a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) and is **OFEV®** being used to slow the rate of decline in pulmonary function?
   ❑ Yes ❑ No

**OR**

4. For **OFEV®:** Does the patient have a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype? ❑ Yes ❑ No

**OR**

5. For **OFEV®** or **Esbriet®**: Does the member have a diagnosis of idiopathic pulmonary fibrosis (IPF)?
   ❑ Yes ❑ No

**AND**

6. Is the patient's baseline percent predicted forced vital capacity (FVC) ≥ 50%? ❑ Yes ❑ No

**AND**

7. Have liver function tests been performed? ❑ Yes ❑ No
   If **Yes**, indicate the date liver function tests were performed: _____

**AND**

**8.** Does the member smoke? ❑ Yes ❑ No

**AND**

**9.** Is the patient female? **If yes, go to question 10; if no, go to question 11.** ❑ Yes ❑ No

**AND**

**10.** Does the member have a negative pregnancy test? ❑ Yes ❑ No

**AND**

**11. Medical Necessity**: Provide clinical evidence that supports the use of the requested medication.

_____

_____

_____

_____

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

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