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®** (pirfenidone)	❑ **Ofev®** (nintedanib)
❑ **pirfenidone**	❑ **nintedanib**

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:** _____

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

(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
4. For **OFEV®:** Does the patient have a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype? ❑ Yes ❑ No
5. For **OFEV®** or **Esbriet®**: Does the member have a diagnosis of idiopathic pulmonary fibrosis (IPF)?
   ❑ Yes ❑ No
6. Is the patient's baseline percent predicted forced vital capacity (FVC) ≥ 50%? ❑ Yes ❑ No
7. Have liver function tests been performed? ❑ Yes ❑ No
   If **Yes**, indicate the date liver function tests were performed: _____
8. Does the member smoke? ❑ Yes ❑ No
9. Is the member female? **If yes, go to question 10; if no, go to question 11.** ❑ Yes ❑ No
10. Does the member have a negative pregnancy test? ❑ Yes ❑ No
11. **Medical Necessity**: Provide clinical evidence that supports the use of the requested medication.

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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.

***REVISED/UPDATED/REFORMATTED:** ~~9/6/2023;~~ **8/11/2026**