

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested (check applicable drug below):

<input type="checkbox"/> Esbriet® (pirfenidone)	<input type="checkbox"/> Ofev® (nintedanib)
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DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Quantity per Day: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: To receive a **ONE (1) year approval** for the listed drugs, **ALL** appropriate boxes below **must** be checked to qualify or authorization process will be delayed.

- Is medication being prescribed by a pulmonologist? Yes No
- Is member 18 years of age or older? Yes No
- Does member have a diagnosis of idiopathic pulmonary fibrosis (IPF)? Yes No
- Member's baseline percent predicted forced vital capacity (FVC) is $\geq 50\%$? Yes No
- Have liver function tests been performed? If yes, indicate the date: _____ Yes No
- Does member smoke? Yes No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

****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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____