US Family Health Plan
Prior Authorization Request Form for
nintedanib esylate **(Ofev)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire after one year.
For renewal of therapy an initial USFHP/ Tricare prior authorization approval is required. **usfamilyhealth.org/rx-pa**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the USFHP/ TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Ofev*	☐ Yes Proceed to question **14**	☐ No Proceed to question **2**
2. Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis (IPF)?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Does the patient have a documented diagnosis of Systemic sclerosis-associated interstitial lung disease (SSc-ILD)?	☐ Yes Proceed to question **11**	☐ No Proceed to question **4**
4. Does the patient have a documented diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
5. Esbriet is the Department of Defense's preferred drug for Idiopathic Pulmonary Fibrosis. Has the patient tried Esbriet?	☐ Yes Proceed to question **6**	☐ No Proceed to question **8**
6. Has the patient failed therapy with Esbriet due to progression of IPF rate of decline of forced vital capacity (FVC) of greater than minus 10%?	☐ Yes Proceed to question **11**	☐ No Proceed to question **7**
7. Has the patient tried Esbriet and experienced intolerable adverse effects (for example rash, photosensitivity, GI adverse events)?	☐ Yes Proceed to question **11**	☐ No Proceed to question **8**
8. Is the patient taking a drug which will interact with Esbriet (for example moderate to strong CYP 1A2 inhibitors)?	☐ Yes Proceed to question **9**	☐ No Proceed to question **10**
9. Please provide the drug name which will interact with Esbriet.	_____ Proceed to question **11**	

10. Does the patient have ESRD AND is on dialysis?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient a smoker?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient being actively managed by a pulmonologist?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient also receiving therapy with Esbriet?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
14. Has the patient continued to refrain from smoking?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is this renewal being submitted by a pulmonologist?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the patient also receiving therapy with Esbriet?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. Has the patient experienced a significant reduction in the annual rate of decline of forced vital capacity (FVC)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date