

**USFHP Prior Authorization Request Form for  
nerandomilast (Jascayd)**

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**

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

**Prior authorization expires in 12 months. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely. Usage for progressive pulmonary fibrosis is not approved at this time.**

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

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID # _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

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

**2**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 13	<input type="checkbox"/> No Proceed to question 2
2. Provider acknowledges pirfenidone (Esbriet generic) is the Department of Defense's preferred drug for Idiopathic Pulmonary Fibrosis (IPF).	<input type="checkbox"/> Acknowledged Proceed to question 3	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Is the requested medication being prescribed by a pulmonologist?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
5. Is the patient a smoker?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 6
6. What is the indication or diagnosis?	<input type="checkbox"/> Documented idiopathic pulmonary fibrosis (IPF)– Proceed to question 7 <input type="checkbox"/> Progressive pulmonary fibrosis - <b>STOP – Coverage not approved</b> <input type="checkbox"/> Other diagnosis – <b>STOP – Coverage not approved</b>	

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7. Does the patient require nerandomilast (Jascayd) as add-on therapy OR monotherapy?	<input type="checkbox"/> Add-on therapy – Proceed to question 8 <input type="checkbox"/> Monotherapy - Proceed to question 10	
8. Has the patient tried and failed pirfenidone (Esbriet generic) due to progression of disease as defined as greater than 10% decline of forced vital capacity (FVC)?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Proceed to question 9
9. Has the patient tried and failed nintedanib (Ofev) due to progression of disease as defined as greater than 10% decline of forced vital capacity?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
10. Has the patient tried and failed pirfenidone (Esbriet generic) and experienced intolerable adverse effects (for example, rash, photosensitivity; GI adverse events) or is taking a drug that will interact with pirfenidone (Esbriet generic)?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Proceed to question 11
11. Has the patient tried and failed nintedanib (Ofev) due to experiencing intolerable adverse effects (for example, rash, photosensitivity; GI adverse events) or is taking a drug that will interact with nintedanib (Ofev)?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
12. Is the patient receiving triple therapy with nerandomilast (Jascayd), pirfenidone (Esbriet, generics), and nintedanib (Ofev)?	<input type="checkbox"/> Yes <b>STOP</b> <b>Coverage not approved</b>	<input type="checkbox"/> No <b>Sign and date below</b>
13. Is the requested medication being prescribed by a pulmonologist?	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
14. Has the patient shown clinical benefit with therapy?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>

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

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date