Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

IPF Agents (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of IPF Agents (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Esbriet (pirfenidone) Ofev (nintedanib)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 6.]

2. Has the member's forced vital capacity (FVC) stabilized or improved since starting the medication? Y N

   Note: Discontinuation of therapy is recommended if there is a greater than 10 percent decline in FVC over a 12 month period.

   [If no, then no further questions.]

3. Are liver function tests (LFTs) being monitored? Y N

   [If no, then no further questions.]

4. Is the member compliant with treatment? Y N

   [If no, then no further questions.]

5. Is the member a current smoker? Y N

   [No further questions.]

6. Does the member have a diagnosis of idiopathic pulmonary fibrosis which has been confirmed by high resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP? Y N

   [If no, then no further questions.]

7. Does the member have a baseline forced vital capacity (FVC) of at least 50 percent predicted? Y N

   [If no, then no further questions.]

8. Does the member have a baseline carbon monoxide diffusion capacity (DLco) of at least 30 percent? Y N

   [If no, then no further questions.]

9. Is there documentation of baseline liver function tests (LFTs) prior to initiating treatment? Y N

   [If no, then no further questions.]

10. Is the member at least 18 years of age? Y N

    [If no, then no further questions.]

11. Is the member a current smoker? Y N

    [If yes, then no further questions.]

12. Is therapy being prescribed by, or in consultation with, a pulmonologist? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**