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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION ESBRIET® (pirfenidone) OR OFEV® (nintedanib)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Esbriet® or OFEV® – to receive a ONE (1) year approval for this drug, complete the following questions:

1. Is the medication being prescribed by a pulmonologist? **AND**
   ☐ Yes ☐ No
2. Is the member 18 years of age or older? **AND**
   ☐ Yes ☐ No
3. For OFEV®: Does the member 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? **OR**
   ☐ Yes ☐ No
4. For OFEV®: Does the member have a diagnosis of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype? **OR**
   ☐ Yes ☐ No
5. For OFEV® or Esbriet®: Does the member have a diagnosis of idiopathic pulmonary fibrosis (IPF)? **AND**
   ☐ Yes ☐ No
6. Is the member's baseline percent predicted forced vital capacity (FVC) ≥ 50%? **AND**
   ☐ Yes ☐ No
7. Have liver function tests been performed? **AND**
   ☐ Yes ☐ No

   If **Yes**, indicate the date liver function tests were performed: _____
8. Does the member smoke? **AND**
   ☐ 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? **AND**
    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

11. **Medical Necessity:** Provide clinical evidence that supports the use of the requested medication.

_____

_____

_____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.