

# INTERSTITIAL LUNG DISEASE PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

Date of Service (if differs from Today's Date): \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis: <input type="checkbox"/> Systemic sclerosis-associated interstitial lung disease (SSc-ILD) <input type="checkbox"/> Chronic fibrosing interstitial lung disease (ILD) <input type="checkbox"/> Idiopathic pulmonary fibrosis (IPF) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____ 3. Will the patient be using the requested agent in combination with another target agent for the requested indication? (e.g., Esbriet, Ofev, pirfenidone)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., pathologist, pulmonologist, radiologist, rheumatologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____ 6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For idiopathic pulmonary fibrosis (IPF) requests:**

7. Have other known causes of interstitial lung disease (ILD) been excluded (e.g., domestic and occupational environmental exposures, connective tissue diseases, drug toxicities, alternative diagnoses)? .....  Yes  No
8. Has the patient had a high-resolution computed tomography (HRCT) scan with results showing a pattern for usual interstitial pneumonia (UIP)? .....  Yes  No
9. Has the patient had a surgical lung biopsy with pathology confirming UIP? .....  Yes  No
10. Has the patient had a HRCT scan with results showing a pattern for probable UIP AND a surgical lung biopsy with pathology indicating probable UIP? .....  Yes  No

**For chronic fibrosing interstitial lung disease (ILD) requests:**

11. Does the patient have TWO of the following occurring within the past year: 1) worsening respiratory symptoms, 2) physiological evidence of disease progression, or 3) radiological evidence of disease progression? .....  Yes  No
12. Have alternative explanations of worsening features been excluded? .....  Yes  No

**For systemic sclerosis-associated interstitial lung disease (SSc-ILD) requests:**

13. Has the patient's diagnosis been confirmed on high-resolution computed tomography (HRCT) or chest radiography scans? .....  Yes  No
14. Has the patient tried and had an inadequate response to ONE prerequisite agent (e.g., mycophenolate mofetil, cyclophosphamide, azathioprine)? .....  Yes  No

If no, does the patient have an intolerance or hypersensitivity to ONE prerequisite agent? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to ALL prerequisite agents? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_

**For brand Esbriet requests:**

- Please submit chart notes to support the answers to the following questions:

15. Has the patient tried and had an inadequate response to generic pirfenidone? .....  Yes  No
16. Does the patient have an intolerance or hypersensitivity to generic pirfenidone that is NOT expected to occur with the requested brand agent? .....  Yes  No
17. Does the patient have an FDA labeled contraindication to generic pirfenidone that is NOT expected to occur with the requested brand agent? .....  Yes  No
18. Was generic pirfenidone discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
19. Is generic pirfenidone expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
20. Is generic pirfenidone NOT in the best interest of the patient based on medical necessity? .....  Yes  No
21. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic pirfenidone, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
22. Is there support for the use of the requested brand agent over generic pirfenidone? .....  Yes  No

If yes, please provide supporting information: \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<b>For renewal requests:</b> 23. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 <b>TOLL FREE</b>		<b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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