PRIOR AUTHORIZATION REQUEST
Idiopathic Pulmonary Fibrosis Agents

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ❑ INITIAL → ***please answer questions 2 – 8***
   - ❑ CONTINUATION → ***please answer questions 9 – 11***
2. What is the indication/diagnosis?
   - ❑ Mild to moderate Idiopathic pulmonary fibrosis
   - ❑ All other indication/diagnosis ***(please specify):***_____

3.	❑Yes	❑No	Has the diagnosis been confirmed by high resolution computed tomography (HRCT), lung biopsy, or bronchoscopy?
4.	❑Yes	❑No	Is the patient's interstitial lung disease due to another cause (such as rheumatoid arthritis, lupus, systemic sclerosis, asbestos exposure, or hypersensitivity neumonitis)?
5.	❑Yes	❑No	Is the patient's forced vital capacity (FVC) between 50% and 80% predicted?
6.	❑Yes	❑No	Is there documentation which confirms baseline liver function tests (LFT's) prior to initiating treatment?
7.	❑Yes	❑No	Is the patient a current smoker?
8.	❑Yes	❑No	Is this medication being prescribed by, or in consultation with, a pulmonologist?
9.	❑Yes	❑No	Is there documentation which confirms that the FVC is GREATER THAN 10% over a 12 month period?
10.	❑Yes	❑No	Is there documentation that confirms the live function tests (LFT's) are being monitored?
11.	❑Yes	❑No	Is there documentation which confirms that the patient is not a current smoker?

Continued on Page 2

If you have any questions, call: 800-753-2851

PRIOR AUTHORIZATION REQUEST
Idiopathic Pulmonary Fibrosis Agents

Continued from Page 1

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851