



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 pneumonitis)?
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?

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



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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

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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questions, call:
800-753-2851**