PRIOR AUTHORIZATION REQUEST

Idiopathic Pulmonary Fibrosis Agents

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?

[] Initial (If checked, go to 2)

[] Continuation (If checked, go to 10)

2 Is the patient 18 years of age OR older? Yes No
[If no, no further questions.]

3 What is the indication/diagnosis?

If you have any questions, call: 1-888-258-8250

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	[] Mild to moderate idiopathic pulmonary fibrosis (If checked, go to 4)		
	[] Other (If checked, no further questions)		
4	Has the diagnosis been confirmed by high resolution computed tomography (HRCT), lung biopsy, or bronchoscopy? [If no, no further questions.]	Yes	No
5	Is the patient's interstitial lung disease due to another cause (such as rheumatoid arthritis, lupus, systemic sclerosis, asbestos exposure, or hypersensitivity pneumonitis)? [If yes, no further questions.]	Yes	No
6	Is the patient's forced vital capacity (FVC) between 50% and 80% predicted? [If no, no further questions.]	Yes	No
7	Have baseline liver function tests (LFT's) been done prior to initiating treatment? [If no, no further questions.]	Yes	No
8	Is the patient a current smoker? [If yes, no further questions.]	Yes	No
9	Is this medication being prescribed by, or in consultation with, a pulmonologist? [No further questions.]	Yes	No
10	Does the patient have a stable forced vital capacity (FVC)? [NOTE: Recommended to discontinue if there is a GREATER THAN 10% decline in FVC over a 12-month period.] [If no, no further questions.]	Yes	No
11	Are the patient's liver function tests (LFT's) being monitored? [If no, no further questions.]	Yes	No
12	Is the patient currently a smoker?	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

If you have any questions, call: 1-888-258-8250