AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Idiopathic Pulmonary Fibrosis

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for pirfenidone (Esbriet®) and nintedanib (Ofev®). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met:

1. Patient is 40 years of age or older; and
2. Is prescribed by a pulmonologist; and
3. Patient has a diagnosis of idiopathic pulmonary fibrosis as confirmed by one of the following (attach documentation):
   - Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or
   - A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and
4. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity; and
5. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥ 50% predicted; and
6. Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted; and
7. Patient does not have hepatic impairment as defined below:
   - Nintedanib – Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C) or
   - Pirfenidone – Patient does not have severe hepatic impairment (Child-Pugh C); and
8. Patient does not have renal impairment as defined below:
   - Nintedanib – Patient does not have severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease or
   - Pirfenidone – Patient does not have end-stage renal disease requiring dialysis; and
9. Patient is a nonsmoker or has been abstinent from smoking for at least six weeks.

If criteria for coverage are met, initial authorizations will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

- Adherence to pirfenidone (Esbriet®) and nintedanib (Ofev®) is confirmed; and
- Patient is tolerating treatment defined as improvement or maintenance of disease (<10% decline in percent predicted FVC or < 200 mL decrease in FVC); and
- Documentation is provided that the patient has remained tobacco-free; and
- ALT, AST, and bilirubin are assessed periodically during therapy.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

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Non-Preferred: ☐ Esbriet ☐ Ofev

Strength: Dosage Instructions: Quantity: Days Supply:

Is Prescriber a Pulmonologist? ☐ Yes ☐ No

Attach results of high-resolution computed tomography (HRCT) or surgical lung biopsy indicating usual interstitial pneumonia (UIP).

Has prescriber excluded other known causes of interstitial lung disease (ILD)? ☐ Yes ☐ No

Patient has pulmonary function test within the prior 60 days documenting a forced vital capacity (FVC) ≥ 50% predicted:
☐ Yes (attach results) ☐ No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted? ☐ Yes (attach results) ☐ No

Does patient have moderate to severe hepatic impairment? ☐ Yes, Child Pugh B ☐ Yes, Child Pugh C ☐ No

Does patient have moderate to severe renal impairment or end-stage renal disease? ☐ Yes ☐ No

CrCl: Date obtained: Is patient on dialysis? ☐ Yes ☐ No

Patient is a nonsmoker or has been abstinent from smoking for at least 6 weeks? ☐ Yes ☐ No

Renewal Requests:

Patient is adherent to therapy: ☐ Yes ☐ No Patient has remained tobacco-free: ☐ Yes ☐ No

Patient is tolerating treatment defined as improvement or maintenance of disease (attach results):
☐ < 10% decline in percent predicted FVC or ☐ < 200 mL decrease in FVC

ALT, AST, and bilirubin are being assessed periodically: ☐ Yes ☐ No Most recent date obtained:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.