



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Idiopathic Pulmonary Fibrosis Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information							
Member Name (first & last):		Date of Birth:		Gender:		Height:	
				<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:		City:		State:		Weight:	
Prescribing Provider Information							
Provider Name (first & last):		Specialty:		NPI#		DEA#	
Office Address:		City:		State:		Zip Code:	
Office Contact:			Office Phone			Office Fax:	
Dispensing Pharmacy Information							
Pharmacy Name:			Pharmacy Phone:			Pharmacy Fax:	
Requested Medication Information							
<input type="checkbox"/> Esbriet				<input type="checkbox"/> Ofev			
Other, please specify:							
What medication(s) has member tried and failed for this diagnosis? Please specify:							
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): Yes No			Diagnosis:		ICD-10 Code:		
Directions for Use:			Strength:		Dosage Form:		
			Quantity:	Day Supply:	Duration of Therapy/Use:		
Turn-Around Time for Review							
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____				
Clinical Information							
Is FVC ≥40% predicted?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is Carbon Monoxide Diffusion Capacity ≥30%		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were baseline LFTs completed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member a current smoker?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have other known causes of interstitial lung disease been ruled out? (for example, domestic AND occupational environmental exposures, connective tissue disease OR drug toxicity)						<input type="checkbox"/> Yes	<input type="checkbox"/> No
OFEV ONLY:	Is member a female of reproductive potential?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did the female member have a NEGATIVE pregnancy test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Idiopathic Pulmonary Fibrosis							

The diagnosis of idiopathic pulmonary fibrosis is confirmed by ONE of the following:	<input type="checkbox"/> High resolution computed tomography demonstrating usual interstitial pneumonia	<input type="checkbox"/> Surgical lung biopsy with usual interstitial pneumonia
<input type="checkbox"/> Chronic Fibrosing of Interstitial Lung Disease – OFEV ONLY		
Does member have relevant fibrosis (> 10% fibrotic features)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have clinical signs of progression? Check ALL that apply	<input type="checkbox"/> FVC decline ≥10% <input type="checkbox"/> FVC decline ≥5% < 10% with worsening symptoms or imaging <input type="checkbox"/> Worsening symptoms AND imaging in the 24 months prior to screening	
<input type="checkbox"/> Systemic Sclerosis-Associated Interstitial Lung Disease - Ofev only		
Was onset of disease < 7 years (1 st non-Raynaud symptom) ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was fibrosis ≥10% on HRCT scan within last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Requests ONLY:		
Does member have a stable FVC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are LFTs being monitored?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member a current smoker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has member been compliant and adherent to treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required
Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.