



**Request for Prior Authorization  
IDIOPATHIC PULMONARY FIBROSIS AND  
RELATED LUNG DISEASES**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- ii.  $\geq 25\%$  predicted for nerandomilast; and
- d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months:
  - i. A relative decline in the FVC of at least 10% predicted; or
  - ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following:
    - 1. Worsening respiratory symptoms; or
    - 2. Increased extent of fibrosis on HRCT; or
  - iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only.

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:

- 1. Adherence to medication is confirmed; and
- 2. Documentation of a positive response to therapy, defined as meeting at least one of the following:
  - a. Rate of lung function decline slowed; or
  - b. Improved or no worsening of symptoms of cough or shortness of breath; and
- 3. Documentation is provided that the patient has remained free from use of non-prescribed inhalants, including but not limited to vaping and other inhaled products.

**Preferred**

Ofev     Pirfenidone

**Non-Preferred**

Esbriet     Jascayd

**Strength** \_\_\_\_\_ **Dosage Instructions** \_\_\_\_\_ **Quantity** \_\_\_\_\_ **Days Supply** \_\_\_\_\_

**Is Prescriber a Pulmonologist?**     Yes     No

**Does patient utilize non-prescribed inhalants, including but not limited to vaping or other inhaled products, prior to initiating therapy?**     Yes     No

**Has patient been instructed to avoid these products while using requested medication(s)?**  
 Yes     No

**Is patient using nintedanib and pirfenidone concomitantly?**     Yes     No

**Document monotherapy trial with nintedanib or pirfenidone if requesting combination therapy with nerandomilast:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Idiopathic Pulmonary Fibrosis (nerandomilast, nintedanib, or pirfenidone)**

Attach results of HRCT or surgical lung biopsy indicating 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 FVC  $\geq 50\%$  predicted for nintedanib or pirfenidone or  $\geq 45\%$  predicted for nerandomilast:

Yes (attach results)     No

Patient has a %DLco of  $\geq 30\%$  predicted for nintedanib or pirfenidone or  $\geq 25\%$  predicted for nerandomilast?

Yes (attach results)     No

**Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (nintedanib)**

Attach results of HRCT scan showing fibrosis affecting  $\geq 10\%$  of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC  $\geq 40\%$  predicted:

Yes (attach results)     No

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Patient has a %DLco of  $\geq 30$ -89% predicted?

- Yes (attach results)                       No

**Chronic Fibrosing Interstitial Lung Disease with a progressive phenotype (progressive pulmonary fibrosis [PFF]) (nintedanib or nerandomilast)**

Attach results of HRCT scan showing fibrosis affecting  $\geq 10\%$  of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC  $\geq 45\%$  predicted:

- Yes (attach results)                       No

Patient has a %DLco of  $\geq 30$ -79% predicted for nintedanib or  $\geq 25\%$  predicted for nerandomilast?

- Yes (attach results)                       No

Patient has at least one sign of clinical progression of ILD within the last 24 months:

- A relative decline in the FVC of at least 10% predicted
- A relative decline in the FVC of 5-9% predicted combined with at least one of the following:
  - o Worsening respiratory symptoms
  - o Increased extent of fibrosis on HRCT
- A worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only.

**Renewal Requests:**

**Patient is adherent to therapy:**                       Yes                       No

**Patient has remained free from use of non-prescribed inhalants:**                       Yes     No

**Patient has a positive response to therapy, defined as meeting at least one of the following:**

- Rate of lung function decline slowed
- Improved or no worsening of cough or shortness of breath

Other medical conditions to consider: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**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 Health and Human Services, that the member continues to be eligible for Medicaid.*