IOWA Health and Human Services

Request for Prior Authorization
IDIOPATHIC PULMONARY FIBROSIS AND RELATED LUNG DISEASES

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
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 (PA) is required for medications used to treat idiopathic pulmonary fibrosis and related lung diseases. Payment for non-preferred agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent that is FDA approved or compendia indicated for the submitted diagnosis, when applicable. Payment will be considered for patients when the following criteria are met:

1) **Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2) **Is prescribed by a pulmonologist; and**
3) **Patient does not utilize non-prescribed inhalants, including but not limited to vaping or other inhaled products, prior to initiating therapy and has been instructed to avoid these products while using requested medication(s); and**
4) **Concomitant use of nintedanib and pirfenidone will not be considered; and**
5) **Documentation of an inadequate response to monotherapy with nintedanib or pirfenidone, at up to maximally indicated doses, is required prior to combination therapy with nerandomilast; and**
6) **Patient has a diagnosis of idiopathic pulmonary fibrosis (nerandomilast, nintedanib or pirfenidone) as confirmed by one of the following (attach documentation):**
   a. **Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or**
   b. **A surgical lung biopsy demonstrating UIP; and**
   c. **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**
   d. **Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC):**
      i. **≥ 50% predicted for nintedanib or pirfenidone; or**
      ii. **≥ 45% predicted for nerandomilast; and**
   e. **Patient has a carbon monoxide diffusion capacity (%DLco):**
      i. **≥ 30% predicted for nintedanib or pirfenidone; or**
      ii. **≥ 25% predicted for nerandomilast; or**
7) **Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation);**
   a. **Documentation of a HRCT scan showing fibrosis affecting ≥ 10% of the lungs; and**
   b. **Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 40% predicted; and**
   c. **Patient has a %DLco of ≥ 30-89% predicted; or**
8) **Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (progressive pulmonary fibrosis [PFF]) (nintedanib or nerandomilast) as confirmed by the following (attach documentation):**
   a. **Documentation of a HRCT scan showing fibrosis affecting ≥ 10% of the lungs; and**
   b. **Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 45% predicted; and**
   c. **Patient has a %DLco of:**
      i. **≥ 30-79% predicted for nintedanib; or**

ii. ≥ 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 **Non-Preferred**
☐ Nintedanib ☐ Ofev ☐ Pirfenidone ☐ 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 ≥ 50% predicted for nintendanib or pirfenidone or ≥ 45% predicted for nerandomilast:
☐ Yes (attach results) ☐ No

Patient has a %DLco of ≥ 30% predicted for nintedanib or pirfenidone or ≥ 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 ≥ 10% of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC ≥ 40% predicted:
☐ Yes (attach results) ☐ No

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Patient has a %DLco of ≥ 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 ≥ 10% of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC ≥ 45% predicted:
☐ Yes (attach results) ☐ No

Patient has a %DLco of ≥ 30-79% predicted for nintedanib or ≥ 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

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.*