BlueCross BlueShield
Federal Employee Program

JASCAYD
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)									**Provider Information (required)**				
Date:									Provider Name:				
Patient Name:									Specialty:		NPI:		
Date of Birth:		Sex: ○Male ○Female							Office Phone:		Office Fax:		
Street Address:									Office Street Address:				
City:		State:		Zip:					City:		State:	Zip:	
Patient ID: **R**									Physician Signature:				

PHYSICIAN COMPLETES

Jascayd (nerandomilast)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   - ❑**NO** - this is **INITIATION** of therapy, please answer the questions below:
2. What is the patient's diagnosis?
   - ❑Idiopathic pulmonary fibrosis (IPF)
     - a. Has the patient's idiopathic diagnosis been confirmed by a physical exam? ❑Yes ❑No
     - b. Does the patient have a forced vital capacity (FVC) less than or equal to 90% of predicted? ❑Yes ❑No
     - c. Does the patient have a diffusing capacity for carbon monoxide (DLCO) less than or equal to 90% of predicted? ❑Yes ❑No
     - d. Does the patient have a pre-bronchodilator FEV_1/FVC ratio greater than or equal to 70%? ❑Yes ❑No
     - e. Has the patient had high-resolution computed tomography (HRCT) with definite or probable findings of usual interstitial pneumonitis (UIP)? ❑Yes ❑No
     - f. Is there a known cause of the interstitial lung disease/fibrosis? ❑Yes ❑No
   - ❑Progressive pulmonary fibrosis (PPF)
     - a. Is there a presence of fibrotic lung disease with disease extent greater than 10% on high-resolution computed tomography (HRCT)? ❑Yes ❑No
     - b. Does the patient have a forced vital capacity (FVC) greater than or equal to 45% of predicted? ❑Yes ❑No
     - c. Does the patient have a diffusing capacity for carbon monoxide (DLCO) greater than or equal to 25% of predicted? ❑Yes ❑No
     - d. Has the patient had clinical signs of progression defined as worsening respiratory symptoms in the last 24 months? ❑Yes ❑No
     - e. Has the patient had clinical signs of progression defined as an absolute forced vital capacity (FVC) predicted decline greater than or equal to 5 percent OR absolute diffusing capacity for carbon monoxide (DLCO) predicted (corrected for hemoglobin) decline greater than or equal to 10 percent in the last 24 months? ❑Yes ❑No
     - f. Has the patient had clinical signs of progression defined as radiologic progression based on high-resolution computed tomography (HRCT) in the last 24 months? ❑Yes ❑No
   - ❑Other diagnosis ***(please specify)*****:** _____
3. Has a drug interaction assessment been performed by the physician? ❑Yes ❑No
4. Is this medication being prescribed by or recommended by a pulmonologist? ❑Yes ❑No

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Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: ○Male ○Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:	Zip:	City:		State:	Zip:
Patient ID: R				Physician Signature:			

PHYSICIAN COMPLETES

CONTINUATION OF THERAPY (PA RENEWAL)

Jascayd (nerandomilast)

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Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   ❑**NO** - this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. What is the patient's diagnosis?
   ❑Idiopathic pulmonary fibrosis (IPF)
   ❑Progressive pulmonary fibrosis (PPF)
   ❑Other diagnosis ***(please specify):*** _____
3. Has an assessment by a healthcare professional shown the medication has slowed the rate of decline of lung function in this patient? ❑Yes ❑No
4. Has an assessment by a healthcare professional shown the medication has improved (or has no decline in) symptoms of cough or shortness of breath in this patient? ❑Yes ❑No
5. Has an assessment by a healthcare professional shown the medication to cause an improved sense of well-being in this patient? ❑Yes ❑No
6. Has a drug interaction assessment been performed by the physician? ❑Yes ❑No