BlueCross BlueShield Federal Employee Program

OFEV
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					

Ofev (nintedanib)

****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 Ofev 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?
   ❑Chronic fibrosing Interstitial Lung Disease (ILD)
   a. Does the patient have a progressive phenotype? ❑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 documented diffusing capacity for carbon monoxide (DL_{CO}) between 30% to 79% of predicted? ❑Yes ❑No
   d. Has Ofev been prescribed by or recommended by a pulmonologist? ❑Yes ❑No

   ❑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*
   ***If NO**, does the patient have a diffusing capacity for carbon monoxide (DL_{CO}) less than or equal to 90% of predicted? ❑Yes ❑No
   c. Does the patient have a pre-bronchodilator FEV1/FVC ratio greater than or equal to 70%?? ❑Yes ❑No
   d. Has the patient had a CT scan with classic findings of usual interstitial pneumonitis (UIP)? ❑Yes ❑No
   e. Has Ofev been prescribed by or recommended by a pulmonologist? ❑Yes ❑No
   f. Is there a documented cause of the interstitial lung disease/fibrosis? ❑Yes ❑No
   g. Will Ofev be used in combination with another Prior Authorization (PA) medication for IPF? ❑Yes* ❑No
   ***If YES**, specify the medication: _____
   PA Medication: Esbriet (pirfenidone)

   ❑Systemic sclerosis-associated Interstitial Lung Disease (ILD)
   a. Does the patient have a forced vital capacity (FVC) greater than or equal to 40% of predicted? ❑Yes ❑No
   b. Does the patient have a documented diffusing capacity for carbon monoxide (DL_{CO}) between 30% to 89% of predicted? ❑Yes ❑No
   c. Has Ofev been prescribed by or recommended by either a pulmonologist or rheumatologist? ❑Yes ❑No

   ❑Other diagnosis ***(please specify):*** _____

3. Has the patient had baseline liver function tests performed? ❑Yes ❑No

4. Has a drug interaction assessment been performed by the physician? ❑Yes ❑No

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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)

Ofev (nintedanib)

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

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

1. Has the patient been on Ofev 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?
   ❑Chronic fibrosing Interstitial Lung Disease (ILD)
   ❑Idiopathic Pulmonary Fibrosis (IPF)
      a. Will Ofev be used in combination with another Prior Authorization (PA) medication for IPF? ❑Yes* ❑No
         If YES, specify the medication: _____
         PA Medication: Esbriet (pirfenidone)
   ❑Systemic sclerosis-associated Interstitial Lung Disease (ILD)
   ❑Other diagnosis ***(please specify):*** _____

3. Has an assessment by a healthcare professional shown Ofev has slowed the rate of decline of lung function in this patient? ❑Yes ❑No

4. Has an assessment by a healthcare professional shown Ofev has improved (or no decline in) symptoms of cough or shortness of breath in this patient? ❑Yes ❑No

5. Has an assessment by a healthcare professional shown Ofev 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