CVS caremark

Reference number(s)
7629-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Combined Benefit Management (CBM)	☐
Combined Benefit Management Pharmacy (CBMP)	☐
Medical Benefit Managed Medicaid (MMMB)	☐

Exceptions Criteria

Idiopathic Pulmonary Fibrosis (IPF)

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), and Advanced Control Specialty – Choice Formulary (ACSCF).

Plan Design Summary

This program applies to the idiopathic pulmonary fibrosis (IPF) products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Idiopathic Pulmonary Fibrosis Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

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	Product(s)
Preferred	• Jascayd (nerandomilast) • nintedanib (generic) • Ofev (nintedanib) • pirfenidone (generic)
Target	• Esbriet (pirfenidone)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred products.

Coverage for Esbriet is provided when both of the following criteria are met:

- Member has had a documented intolerable adverse event to the preferred product generic pirfenidone, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
- Member has a documented inadequate response or intolerable adverse event with a preferred nintedanib product (Ofev or generic nintedanib) and Jascayd.

References

1. Esbriet [package insert]. South San Francisco, CA: Genentech, Inc.; February 2023.
2. Jascayd [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; August 2026.
3. Nintedanib [package insert]. Parsippany, NJ: Edenbridge Pharmaceuticals, LLC; July 2026.
4. Ofev [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; May 2025.
5. Pirfenidone [package insert]. Bridgewater, NJ: Amneal Pharmaceuticals LLC; February 2025.

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