Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ofev (nintedanib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ofev (nintedanib).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a pulmonologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member is a non-smoker,
   □ No □ Yes

2. **AND** member is not receiving concomitant treatment with pirfenidone or any CYP3A4 inducers,
   □ No □ Yes

3. **AND** pregnancy has been excluded in patients of reproductive potential prior to starting treatment, and patient has been provided with contraceptive counseling on the risks of taking nintedanib if the patient were to become pregnant,
   □ No □ Yes

4. **AND** using for one of the following diagnoses:
   - Idiopathic pulmonary fibrosis (IPF):
     - NO known cause of interstitial lung disease
     - AND patient has tried and failed prior use of pirfenidone (generic Esbriet)

   □ No □ Yes

   - **OR** diagnosis of progressive pulmonary fibrosis

   □ No □ Yes

   - **OR** diagnosis of systemic sclerosis associated with interstitial lung disease (SSc-ILD) with greater than or equal to 10% fibrosis on a chest HRCT scan (conducted within last 12 months)

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member continues to meet initial criteria with positive clinical response,
   □ No □ Yes

2. **AND** hepatic function and spirometry are monitored at least annually,
   □ No □ Yes

3. **AND** member continues to be under the care of a pulmonologist
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**