Prescriber Criteria Form Ofev 2024 PA Fax 1216-A v1 010124.docx Ofev (nintedanib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ofev (nintedanib).

Drug Name: Ofev (nintedanib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of systemic sclerosis-associated interstitial lung disease? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of a chronic fibrosing interstitial lung disease with a progressive phenotype? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of idiopathic pulmonary fibrosis? [If no, then no further questions.]	Yes	No
4	Is the patient currently receiving the requested drug? [If yes, then no further questions.]	Yes	No
5	Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy which shows the usual interstitial pneumonia (UIP) pattern? [If yes, then no further questions.]	Yes	No
6	Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest which shows a result other than the usual interstitial pneumonia (UIP) pattern (e.g., probable UIP, indeterminate for UIP)? [If no, then no further questions.]	Yes	No

7	Has the diagnosis of idiopathic pulmonary fibrosis been supported by a lung biopsy? [If yes, then no further questions.]	Yes	No
8	Has the diagnosis of idiopathic pulmonary fibrosis been supported by a multidisciplinary discussion between at least a pulmonologist and a radiologist who are experienced in idiopathic pulmonary fibrosis?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____