Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Idiopathic Pulmonary Fibrosis Therapy (Esbriet, Ofev)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested
☐ Esbriet 267mg ☐ Esbriet 801mg ☐ Ofev 100mg ☐ Ofev 150mg ICD10:

Directions for use: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose new start of therapy. ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a beneficial clinical response to therapy with this drug? ☐ Yes ☐ No or Unknown
(if no) Please provide clinical support for continued use of this drug.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ idiopathic pulmonary fibrosis (IPF) (ICD10 J84.112)
☐ interstitial lung diseases (ILDs)
☐ systemic sclerosis-associated interstitial lung disease (SSc-ILD)
☐ Other *(please specify)*:

Clinical Information:
(if Ofev for ILDs) Does the patient have chronic fibrosing interstitial lung diseases (ILDs) with progression? ☐ Yes ☐ No
(if Ofev for SSc-ILD) Does the patient have the documented diagnosis of systemic sclerosis (SSc)? ☐ Yes ☐ No
(if Idiopathic Pumonary Fibrosis) Have other potential causes of interstitial lung disease (for example, medication use, environmental exposures at home/work) been excluded? ☐ Yes ☐ No

(if Idiopathic Pumonary Fibrosis) Has the patient had an high-resolution CT scan (HRCT) scan with results showing a pattern that meets BOTH criteria for usual interstitial pneumonia (UIP):
A) Subpleural and basal predominant distribution;
-AND-
B) Honeycombing with or without peripheral traction bronchiectasis or bronchiolectasis? ☐ Yes ☐ No

(if Idiopathic Pumonary Fibrosis) Has the patient had a lung biopsy with pathology confirming UIP? ☐ Yes ☐ No
(if Idiopathic Pumonary Fibrosis) Has the patient had a HRCT scan AND a lung biopsy and BOTH are indicative of probable UIP? ☐ Yes ☐ No
(if Ofev for ILDs/SSc-ILD) Does the patient have documentation of interstitial fibrosing lung disease on high-resolution computed tomography (HRCT)? ☐ Yes ☐ No
(if Ofev for ILDs Does the patient have clinical signs of progression evidenced by a forced vital capacity decline of at least 10% of the predicted value? ☐ Yes ☐ No
(if no) Does the patient have clinical signs of progression evidenced by a forced vital capacity decline from 5% to less than 10% with worsening symptoms and/or worsening imaging? ☐ Yes ☐ No

*****Please include documentation to support the above 8 questions (including chart notes, test results, etc)**

(if Ofev for SSc-ILD and new to therapy) Is this drug being prescribed by, or in consultation with, a pulmonologist or a rheumatologist? ☐ Yes ☐ No

(if Esbriet for IPF or if Ofev for IPF/ILDs or SSc-ILD established pt only) Is this drug being prescribed by, or in consultation with, a pulmonologist? ☐ Yes ☐ No

Will your patient be using Ofev and Esbriet together? ☐ Yes ☐ No

Additional Pertinent Information: *(examples could include past medications tried, labs, pertinent patient history):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**____________________

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v060120

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005