health information designs

Agents Used to Treat Idiopathic Pulmonary Fibrosis Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for agents used to treat idiopathic pulmonary fibrosis must meet the following criteria:

- **Patient must be 18 years of age or older.**
- **Patient must have documented diagnosis of idiopathic pulmonary fibrosis.**
- **Patient must have a specialist involved in therapy.**
- **Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days.**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name	Specialist Involved in Therapy (if different than prescriber)			
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State		Zip Code
Requested Drug:	Diagnosis:		FVC:	Date of FVC Provided:
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*				
Prescriber (or Staff) / Pharmacy Signature**				Date
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #