OFEV® (nintedanib) Capsules Prescription Form

NEW Indication

For Specialty Pharmacy use only: SP Patient ID ________________ Fax: 404-900-9209

STEP 1 PATIENT INFORMATION

Patient Name (First, MI, Last) ____________________ DOB (MM/DD/YY) _____/_____/_____ Gender ☐ M ☐ F

Address ____________________ City ____________________ State ______ Zip ________

Check preferred phone: ☐ Home Phone __________ ☐ Work Phone __________ ☐ Cell Phone __________ ☐ OK to leave message

Best Time to Contact __________ Email __________ Caregiver Name (if applicable) __________

Caregiver Phone __________ Language translation? ☐ Yes ☐ No If yes, please indicate language __________

STEP 2 PRESCRIBER INFORMATION

Prescriber Name (First, Last) __________ Specialty __________ Practice Name __________

Address __________ City __________ State __________ Zip __________

Office Contact __________ Phone __________ Fax __________ *Preferred method of contact*: ☐ Phone ☐ Fax

Medicare/Medicaid # __________ Tax ID # __________ NPI # __________

STEP 3 INSURANCE INFORMATION [Please attach copies of both sides of patient's insurance card(s)]

☐ **Check if this patient does not have insurance.** **If patient has no insurance, please call BI Cares at 855-297-5906, who will help manage the process of determining if the patient qualifies for the BI Cares Foundation Patient Assistance Program (PAP).**

Prescription Drug Insurer Name __________ **Prescription Drug Insurer Phone** __________

Policy ID # __________ **Group #** __________ **Rx BIN #** __________ **Rx PCN #** __________

Primary Insurance __________ **Insurance Phone** __________ **Policy ID #** __________ **Group #** __________

Policy Holder Name (First, Last) __________ **Relationship to Patient** __________

Secondary Insurance __________ **Insurance Phone** __________ **Policy ID #** __________ **Group #** __________

Policy Holder Name (First, Last) __________ **Relationship to Patient** __________

STEP 4 COMPLETE PRESCRIPTION FOR OFEV CAPSULES

☐ **OFEV:** 150 mg capsule BID #60 12 hours apart with food __________ Refills ☐ **OFEV:** 100 mg capsule BID #60 12 hours apart with food __________ Refills

Special instructions: __________

Select Specialty Pharmacy (*required*) ***Please select one of the following Specialty Pharmacies and send the prescription to them directly.***

☐ **Accredo Specialty Pharmacy**
Phone: (844) 708-0093; Fax: (888) 445-4581
For Accredo Patients Only:
☐ **I do not want this patient to receive loperamide in their OFEV Welcome Kit.**

☐ **Advanced Care Scripts**
Phone: (855) 252-5715; Fax: (866) 679-7131

☐ **AllianceRx Walgreens Prime**
Phone: (800) 445-3674; Fax: (866) 773-0143

☐ **CVS/Caremark**
Phone: (800) 506-5276; Fax: (877) 943-1000

☐ **DIPLOMAT**
Phone: (877) 369-5715; Fax: (866) 810-7998

☐ **Humana Specialty Pharmacy**
Phone: (855) 425-3994; Fax: (855) 201-4396

☐ **OPTUM Specialty Pharmacy**
Phone: (855) 312-9074; Fax: (877) 746-9166

☐ **Orsini Healthcare**
Phone: (800) 373-1452; Fax: (888) 975-1456

Statement of medical necessity

Primary diagnosis: ICD-10 code ☐ **J84.112 Idiopathic Pulmonary Fibrosis** ☐ **M34.81 Systemic Sclerosis With Lung Involvement**
☐ **J84.10 Pulmonary Fibrosis, Unspecified** ☐ **Other ICD-10:** __________

☐ Secondary Diagnosis: __________

☐ **Concurrent therapy:** __________ Dates/duration __________ ☐ No concurrent therapy

☐ **Prior therapy:** __________ Dates/duration __________ ☐ No prior therapy

Known allergies: __________ Is patient on oxygen therapy? Yes ________ No ________

SIGN AND DATE HERE

Prescriber Authorization* *Prescriber's Signature* __________ Date __________
(Brand Necessary)

Prescriber Authorization* *Prescriber's Signature* __________ Date __________
(Substitution Permitted)

By your acknowledgment and signature above, an authorization is provided to dispense the prescription as written including a patient welcome kit with an associated supply of loperamide.

STEP 5 OFEV BRIDGE PROGRAM PRESCRIPTION (OPTIONAL)

Patients may receive up to 60 days of their medication while their insurance coverage is being determined through the OFEV Bridge Program. Please complete the prescription below.

☐ **OFEV**: 150 mg capsule BID #30, with 3 refills; take 12 hours apart with food ☐ **OFEV**: 100 mg capsule BID #30, with 3 refills; take 12 hours apart with food

The OFEV Bridge Program is available for most insured patients prescribed OFEV for US Food and Drug Administration approved indication without regard to purchase of OFEV or any other product.

SIGN AND DATE HERE

Prescriber Authorization* *Prescriber's Signature* __________ Date __________
(Brand Necessary)

Prescriber Authorization* *Prescriber's Signature* __________ Date __________
(Substitution Permitted)

*Signature stamps not acceptable. If required by applicable law, please attach copies of all prescriptions on official state prescription forms. Prescription is valid only if received by fax.
Special Note: New York Prescribers, please submit prescription on an original NY State prescription blank. For all other States, if not faxed, must be on State-specific blank if applicable for your State.

When completed, please fax to your choice of ONE of the Specialty Pharmacies listed in Step 4.