

## ANTIFIBROTIC RESPIRATORY AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antifibrotic Respiratory Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (powder, tablet, etc.):	
Dose/directions:		Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		DX code ( <i>required</i> ):	
Is the medication being prescribed by or in consultation with a pulmonologist, rheumatologist, or other specialist?		<input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No	
Is the beneficiary currently being treated with the requested medication?		<input type="checkbox"/> Yes <i>If yes, submit documentation.</i> <input type="checkbox"/> No	
If applicable, has the dose of the requested medication been adjusted for the beneficiary's degree of liver impairment, concomitant medications, adverse effects, etc.?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No	

#### INITIAL requests

<b>For a non-preferred Antifibrotic Respiratory Agent</b> , does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to the preferred Antifibrotic Respiratory Agents appropriate for the beneficiary's diagnosis or indication? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Is the beneficiary a current smoker? If yes, did the prescriber advise the beneficiary to stop smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

#### RENEWAL requests

Has the beneficiary experienced a positive clinical response to the requested medication?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Did the beneficiary experience any adverse reactions that require dose adjustment as described in the FDA-approved product labeling (e.g., liver enzyme elevations, GI reaction, photosensitivity reaction, rash)?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

**Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

Prescriber Signature:	Date:
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