

OFEV® (nintedanib) Prescription Form



For Specialty Pharmacy use only: SP Patient ID _____

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 the OPEN DOORS™ patient support program at 1-866-OPENDOOR (1-866-673-6366) to obtain an application for the BI Cares 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.

<input type="checkbox"/> Accredo Specialty Pharmacy Phone: (844) 708-0093; Fax: (888) 445-4581 For Accredo Patients Only: <input type="checkbox"/> I do not want this patient to receive loperamide in their OFEV Welcome Kit.	<input type="checkbox"/> Acro Pharmaceutical Services Phone: (800) 906-7798; Fax: (855) 439-4768	<input type="checkbox"/> BriovaRx Phone: (855) 312-9074; Fax: (877) 746-9166	<input type="checkbox"/> Humana Specialty Pharmacy Phone: (800) 486-2668; Fax: (800) 345-8534
<input type="checkbox"/> Advanced Care Scripts/Omnicare Phone: (855) 252-5715; Fax: (866) 679-7131	<input type="checkbox"/> AllianceRx Walgreens Prime Phone: (800) 445-3674; Fax: (866) 773-0143	<input type="checkbox"/> CVS/Caremark Phone: (800) 506-5276; Fax: (800) 323-2445	<input type="checkbox"/> Orsini Healthcare Phone: (800) 373-1452; Fax: (888) 975-1456

Statement of medical necessity
Primary diagnosis: ICD-10 code J84.112 Idiopathic Pulmonary Fibrosis Other ICD-10: _____ Secondary Diagnosis: _____
Prior therapy: Current or most recent therapy _____ Dates/duration _____ No prior therapies
Known allergies: _____ Is patient on oxygen therapy? Yes _____ No _____
 Skilled nursing and/or clinical visits to educate patient on OFEV administration and dosing, adherence to regimen, including dosing modification and disease state awareness to understand patient's response to therapy.

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.

OFEV® (nintedanib) Prescription Instructions



For assistance with this form or additional information, call our patient support program at 1-866-OPENDOOR (1-866-673-6366), Monday–Friday, 8:00 AM to 8:00 PM

GUIDE TO COMPLETING THE PRESCRIPTION FORM

CHECK ITEMS UPON COMPLETION

STEP 1

Patient Demographic Information

STEP 2

Prescriber Demographic Information

STEP 3

Patient Insurance Information

If the patient does not have insurance, please call the OPEN DOORS™ patient support program at 1-866-OPENDOOR (1-866-673-6366) to obtain a BI Cares PAP Application.

STEP 4

Prescription & Prescriber Signature

(NOTE: Omission of signature will result in processing delays.)

Please select one of the following Specialty Pharmacies and send the COMPLETED prescription to them directly.

Accredo Specialty Pharmacy
Acro Pharmaceutical Services
Advanced Care Scripts/Omnicare
AllianceRx Walgreens Prime
BriovaRx
CVS/Caremark
Humana Specialty Pharmacy
Orsini Healthcare

Phone: (844) 708-0093
Phone: (800) 906-7798
Phone: (855) 252-5715
Phone: (800) 445-3674
Phone: (855) 312-9074
Phone: (800) 506-5276
Phone: (800) 486-2668
Phone: (800) 373-1452

Fax: (888) 445-4581
Fax: (855) 439-4768
Fax: (866) 679-7131
Fax: (866) 773-0143
Fax: (877) 746-9166
Fax: (800) 323-2445
Fax: (800) 345-8534
Fax: (888) 975-1456

STEP 5

OFEV Bridge Program Prescription & Prescriber Signature (for insured patients only)

(NOTE: Omission of signature will result in processing delays.)

OFEV Bridge Pharmacy (for pharmacy use only)

Phone: (800) 373-0813

Fax: (888) 975-1454

Fax the COMPLETED form to chosen Specialty Pharmacy from the list provided in Step 4.

The image shows a thumbnail of the OFEV (nintedanib) Prescription Form. It is divided into five numbered steps: 1. Patient Demographic Information, 2. Prescriber Demographic Information, 3. Insurance Information, 4. Complete Prescription for OFEV Capsules, and 5. Complete Prescription Options. Each step includes various fields for patient and prescriber details, insurance information, and signature lines. Step 5 includes a section for specialty pharmacies.

Thank you for completing the form.

Page 2 of 2: Please fax to your choice of ONE of the Specialty Pharmacies provided in Step 4.

Additional forms can be obtained at www.OFEV.com or by calling the OPEN DOORS™ patient support program at 1-866-OPENDOOR (1-866-673-6366).