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.***

☐ **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.**

☐ **Acro Pharmaceutical Services**
Phone: (800) 906-7798; Fax: (855) 439-4768

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

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

☐ **BriovaRx**
Phone: (855) 312-9074; Fax: (877) 746-9166

☐ **CVS/Caremark**
Phone: (800) 506-5276; Fax: (800) 323-2445

☐ **Humana Specialty Pharmacy**
Phone: (800) 486-2668; Fax: (800) 345-8534

☐ **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.

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

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	Phone: (844) 708-0093	Fax: (888) 445-4581
Acro Pharmaceutical Services	Phone: (800) 906-7798	Fax: (855) 439-4768
Advanced Care Scripts/Omnicare	Phone: (855) 252-5715	Fax: (866) 679-7131
AllianceRx Walgreens Prime	Phone: (800) 445-3674	Fax: (866) 773-0143
BriovaRx	Phone: (855) 312-9074	Fax: (877) 746-9166
CVS/Caremark	Phone: (800) 506-5276	Fax: (800) 323-2445
Humana Specialty Pharmacy	Phone: (800) 486-2668	Fax: (800) 345-8534
Orsini Healthcare	Phone: (800) 373-1452	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.**

Thank you for completing the form.

 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).

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