

OFEV® (nintedanib) Capsules 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.
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 Health Group Inc. Phone: (844) 708-0093; Fax: (888) 445-4581
For Accredo Patients Only: **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
 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
 I do not want this patient to receive loperamide in their OFEV Welcome Kit.
Diagnosis: ICD-10 code J84.112 Idiopathic Pulmonary Fibrosis J84.10 Pulmonary Fibrosis, Unspecified
 M34.81 Systemic Sclerosis With Lung Involvement Other ICD-10: _____
 J84.170 Interstitial lung disease with a progressive fibrotic phenotype in diseases classified elsewhere*
*Underlying disease/ICD-10 code if available: _____
 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.

OPTIONAL STEP FOR OFEV SPECIALTY PHARMACY BRIDGE ORDERS ONLY

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.



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

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 Health Group Inc.

Phone: (844) 708-0093

Fax: (888) 445-4581

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

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

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

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).

OPTIONAL STEP - FOR OFEV SPECIALTY PHARMACY BRIDGE ORDERS ONLY

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

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.OFEVHCP.com

