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:
☐ **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

☐ **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

Diagnosis: ICD-10 code

☐ **J84.112 Idiopathic Pulmonary Fibrosis**
☐ **M34.81 Systemic Sclerosis With Lung Involvement**
☐ **J84.170 Interstitial lung disease with a progressive fibrotic phenotype in diseases classified elsewhere***
*Underlying disease/ICD-10 code **if available:** _____

☐ **J84.10 Pulmonary Fibrosis, Unspecified**
☐ **Other ICD-10:** _____

☐ **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)

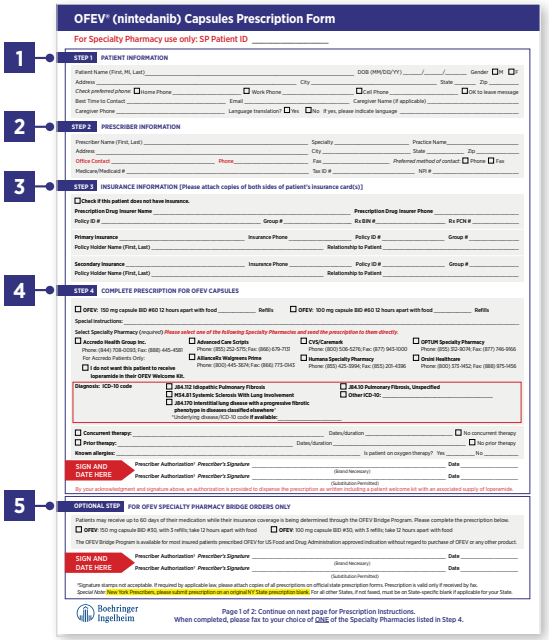
†Signature stamps not acceptable. If required by applicable law, please attach copies of all prescriptions on official state prescription forms. Prescription is valid only if received by fax.
Special Note: New York Prescribers, please submit prescription on an original NY State prescription blank. For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

Boehringer Ingelheim

Page 1 of 2: Continue on next page for Prescription Instructions.
When completed, please fax to your choice of ONE of the Specialty Pharmacies listed in Step 4.

OFEV® (nintedanib) Capsules Prescription Instructions

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

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