



**GEORGIA MEDICAID FEE-FOR-SERVICE
PULMONARY FIBROSIS AGENTS PA SUMMARY**

Preferred	Non-Preferred
n/a	Esbriet (pirfenidone) Ofev (nintedanib)

LENGTH OF AUTHORIZATION: 1 Year

PA CRITERIA:

- ❖ Approvable for members 40 years of age and older with confirmed idiopathic pulmonary fibrosis who have a forced vital capacity (FVC) >50% of predicted
AND
- ❖ Must be prescribed by or in consultation with a pulmonologist.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to <http://dch.georgia.gov/prior-authorization-process-and-criteria> and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the Quantity Level Limits (QLL), please go to <https://www.mmis.georgia.gov/portal>, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.