Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Jascayd (nerandomilast)**

Effective: June 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

JASCAYD is a phosphodiesterase 4 (PDE4) inhibitor indicated for the treatment of idiopathic pulmonary fibrosis (IPF) in adult patients and the treatment of progressive pulmonary fibrosis in adult patients (PPF).

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Jascayd for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of idiopathic pulmonary fibrosis (IPF) or progressive pulmonary fibrosis (PPF)

AND

2. Documentation diagnosis is confirmed by both of the following:
    a. High-resolution CT (HRCT) confirming Usual Interstitial Pneumonia (UIP) pattern
    b. Lung function tests /Pulmonary function tests demonstrate a Forced Vital Capacity (FVC) decline of ≥10% or ≥45% of predicted normal
3. AND
4. Other known causes of interstitial lung disease (e.g., domestic, occupational, environmental exposures, connective tissue disease, drug toxicity) have been ruled out

AND

5. The patient is at least 18 years of age or older

AND

6. Prescribed by, or in consultation with a pulmonologist

AND

7. Documented insufficient response or contraindication to ALL of the following:
    a. Ofev
    b. Esbriet (pirfenidone)

Reauthorization Criteria

1. Attestation of evidence of improvement or stabilization or IPF or PPF from provider, or attestation that discontinuation of Jascayd is likely to result in more rapid disease progression

Limitations

1. Initial approval of Jascayd will be authorized for twelve (12) months. Reauthorization will be provided in twelve (12) month intervals.

Codes

None

References

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Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- May 9, 2023: No changes
- March 12, 2024: No changes
- January 14, 2025: No changes (eff 1/14/25).
- May 12, 2026: No changes, Template updated to remove CareLink from the Medical Necessity Guideline template.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed

revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.