PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Esbriet (pirfenidone)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is Esbriet being prescribed for (pick one)?

☐ Idiopathic Pulmonary Fibrosis ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis

Q3. Is prescribing physician a Pulmonary specialist?

☐ Yes ☐ No

Q4. Is the patient a NEW start to Esbriet therapy?

☐ Yes ☐ No (please provide start date)

Q5. For the treatment of mild to moderate Idiopathic Pulmonary Fibrosis, have all other known causes of interstitial lung disease (e.g. occupational and domestic environmental causes, connective tissue disease, and drug toxicity) been excluded?

☐ Yes ☐ No

Q6. Is the patient's baseline forced vital capacity (FVC) greater than or equal to 50% of predicted value?

☐ Yes ☐ No

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Q7. For treatment of Idiopathic Pulmonary Fibrosis, how was the diagnosis made?

- ☐ High resolution computed tomography (HRCT) confirming usual interstitial pneumonia (UIP)
- ☐ Surgical lung biopsy confirming UIP
- ☐ Other (Please Specify)

Q8. Please select all of the following that apply to this patient.

- ☐ Severe hepatic impairment (Child-Pugh Class C)
- ☐ Concurrent use of Ofev
- ☐ Current smoked tobacco user
- ☐ None of the above

Q9. For continuation of therapy, has patient demonstrated a response to therapy defined as an annual decline in FVC of less than 10%?

☐ Yes ☐ No

Q10. For continuation of therapy, was clinical documentation submitted confirming lack of moderate (Child Pugh B) or severe hepatic impairment (Child Pugh C) AND abstinence from smoking?

☐ Yes ☐ No

Q11. Additional Comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.