Esbriet (pirfinidone) Prior Authorization Request Form

Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUM	BER:			
MALE FEMALE HEIG				
IF YOU ARE NOT THE PATIENT OR THE PRESCRIB FOLLOWING LINK: <u>PRIMETHERAPEUTICS.COM/N</u>		OSURE AUTHORIZATION FORM WITH THIS REC	QUEST WHICH CAN BE FOUND AT THE	
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:				
PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:	:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL D	ISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
NEW THERAPY DURATION OF THERAPY (SPEC	RENEWAL			
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MEDICATION/THERAPY (SPECIFY DATES): DURATION OF THERAPY (SPECIFY DATES): RESPONSE/REASON FOR FAILURE/ALLERGY: Idiopathic pulmonary fibrosis	MEMBER'S LAST NAME: MEMBER'S FIRST NAME:		NAME:
DATES): DATES : FAILURE/ALLERGY:	1. HAS THE PATIENT TRIED ANY OTH	ER MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO
2. LIST DIAGNOSES: □ Idiopathic pulmonary fibrosis □ Other diagnosis: □ ICD-10 Code(s): □ ICD-10 Cod		DURATION OF THERAPY (SPECIFY	-
□ Idiopathic pulmonary fibrosis □ Other diagnosis: □ ICD-10 Code(s): □ ICD-10 Code(DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:
□ Idiopathic pulmonary fibrosis □ Other diagnosis: □ ICD-10 Code(s): □ ICD-10 Code(
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. Clinical Information: Will Esbriet (pirfenidone) be used concurrently with Ofev (nintedanib) therapy? □ Yes □ No Is high resolution CT of the chest consistent with a diagnosis of idiopathic pulmonary fibrosis? □ Yes □ No (Please submit imaging report.) Does the patient have a forced vital capacity (FVC) of 50-90% predicted?* □ Yes □ No Is the patient's carbon monoxide (CO) diffusing capacity 30-90% predicted?* □ Yes □ No Does the patient have a forced expiratory volume in 1 second/forced vital capacity (FEV1:FVC) ratio ≥ 0.80?* □ Yes □ No *Please provide supporting documentation including a pulmonary function test (PFT) report and/or other chart notes. Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received. ATTESTATION: □ attest the information provided is true and accurate to the best of my knowledge. □ understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form. Prescriber Signature or Electronic I.D. Verification: Date: CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If	2. LIST DIAGNOSES:		ICD-10:
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you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX)			



and arrange for the return or destruction of these documents.

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Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

