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 NUMBER:	

☐ MALE   ☐ FEMALE   HEIGHT (IN/CM): _____   WEIGHT (LB/KG): _____   ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

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 DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
☐ NEW THERAPY ☐ RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	ICD-10:
☐ Idiopathic pulmonary fibrosis ☐ Other diagnosis: _____ ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is patient going to be using drug in combination with a clinical trial? ☐ Yes ☐ No

Initial Request:
Is prescriber a pulmonologist? ☐ Yes ☐ No
Will patient will use Esbriet® (pirfenidone) in combination with Ofev(nintedanib)? ☐ Yes ☐ No
Will patient will use Esbriet® (pirfenidone) in combination with Jascayd® (nerandomilast)? ☐ 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.

Renewal Request:
Is patient continuing to demonstrate a positive clinical response? ☐ Yes ☐ No *Please submit documentation.*
Is prescriber a pulmonologist? ☐ Yes ☐ No
Will patient will use Esbriet® (pirfenidone) in combination with Ofev(nintedanib)? ☐ Yes ☐ No
Will patient will use Esbriet® (pirfenidone) in combination with Jascayd® (nerandomilast)? ☐ Yes ☐ No

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.

Prime THERAPEUTICS™

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I 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 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.

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