{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

1. What is the prescribed product?
   ❑ Ofev ❑ pirfenidone 534mg ❑ generic pirfenidone (excluding 534mg) ❑ Esbriet
2. What is the diagnosis?
   ❑ Idiopathic pulmonary fibrosis (IPF) ❑ Other _____
3. What is the ICD-10 code? _____

Section A: Preferred Product - *Complete this section if pirfenidone 534mg is prescribed*

4. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. The formulary alternatives for the requested drug are Ofev and generic pirfenidone (excluding 534mg). Can the patient's treatment be switched to a formulary alternative? ***If Yes, pirfenidone, please fax a new prescription to the pharmacy and skip to Section C: All Requests.***
   ❑ Yes, *please specify:* _____
   ❑ No - Continue request for non-preferred product
5. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Formulary alternative(s): Ofev and generic pirfenidone (excluding 534mg). ❑ Yes ❑ No

   If Yes, indicate the formulary alternative(s) the patient has tried and the reason(s) for treatment failure and skip to #7.

   Drug name: _____ Reason for treatment failure: _____

   Drug name: _____ Reason for treatment failure: _____
6. Does the patient have a documented contraindication to all or at least three of the formulary alternative(s): Ofev and generic pirfenidone (excluding 534mg)? ❑ Yes ❑ No

   If Yes, specify the formulary alternative(s) the patient is unable to take and describe the contraindication(s):

   Drug name: _____ Contraindication: _____

   Drug name: _____ Contraindication: _____
7. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three been attached? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.*** ❑ Yes ❑ No *Skip to Section C: All Requests*

Section B: Preferred Product - *Complete this section if Esbriet is prescribed*

8. The preferred products for your patient's health plan are Ofev and generic pirfenidone. Can the patient's treatment be switched to a preferred product?
   If Yes, pirfenidone, please fax a new prescription to the pharmacy and skip to Section C: All Requests.
   ❑ Yes, *please specify:* _____
   ❑ No - Continue request for non-preferred product

9. Does the patient have a documented intolerable adverse event to the preferred product, generic pirfenidone?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No

10. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient (pirfenidone) as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).*** ❑ Yes ❑ No

11. Does the patient have a documented inadequate response to the preferred product, Ofev?
    ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to Section C: All Requests
    ❑ Yes ❑ No

12. Does the patient have a documented intolerable adverse event to the preferred product, Ofev?
    ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No

Section C: All Requests

13. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #15*

14. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?
    ❑ Yes
    ❑ No, *no further questions.*
    ❑ Unknown

15. Have other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) been excluded? ❑ Yes ❑ No *If No, no further questions*.

16. Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest?
    ACTION REQUIRED: If Yes, attach the radiology report. ❑ Yes ❑ No *If No, skip to #20*

17. Please indicate what the high-resolution computed tomography (HRCT) scan demonstrates.
    ❑ Usual interstitial pneumonia (UIP) pattern, *no further questions*
    ❑ Other (e.g., probable UIP, indeterminate for UIP, or alternative diagnosis)

18. Has the diagnosis of idiopathic pulmonary fibrosis been supported by a lung biopsy? ***ACTION REQUIRED: If Yes, attach the pathology report and no further questions.*** ❑ Yes ❑ No

19. Has the diagnosis of idiopathic pulmonary fibrosis been supported by a multidisciplinary discussion between at least a pulmonologist and a radiologist who are experienced in idiopathic pulmonary fibrosis?
    ❑ Yes ❑ No *No further questions.*

20. Has the patient undergone a lung biopsy? ***ACTION REQUIRED: If Yes, attach the pathology report.***
    ❑ Yes ❑ No *If No, no further questions.*

21. Please indicate what the biopsy report demonstrates.
    ❑ Usual interstitial pneumonia (UIP) pattern
    ❑ Other _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date