BlueCross BlueShield Federal Employee Program

ESBRIET
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Esbriet (pirfenidone)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑ Brand ❑ Generic

1. Does the patient have a diagnosis of idiopathic pulmonary fibrosis (IPF)? ❑Yes ❑No

2. Has a drug interaction assessment been performed by the physician? ❑Yes ❑No

3. Will this medication be used in combination with another *Prior Authorization (PA) medication for IPF? ❑Yes* ❑No
   If YES, please specify the medication: _____
   PA Medication: Ofev (nintedanib)

4. Has the patient been on Esbriet continuously for the last **4 months**, excluding samples? ***Please select answer below:***

❑**NO** - this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient's idiopathic diagnosis been confirmed by a physical exam? ❑Yes ❑No

b. Does the patient have a forced vital capacity (FVC) less than or equal to 90% of predicted? ❑Yes ❑No*
   If NO, does the patient have a diffusing capacity for carbon monoxide (DLco) less than or equal to 90% of predicted? ❑Yes ❑No

c. Does the patient have a pre-bronchodilator FEV1/FVC ratio greater than or equal to 70%? ❑Yes ❑No

d. Has the patient had a CT scan with classic findings of usual interstitial pneumonitis (UIP)? ❑Yes ❑No

e. Has this medication been prescribed by a pulmonologist? ❑Yes ❑No

f. Has the patient had baseline liver function tests performed? ❑Yes ❑No

g. Is there a documented cause of the interstitial lung disease/fibrosis? ❑Yes ❑No

❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has an assessment by a healthcare professional shown Esbriet has slowed the rate of decline of lung function in this patient? ❑Yes ❑No

b. Has an assessment by a healthcare professional shown Esbriet has improved (or no decline in) symptoms of cough or shortness of breath in this patient? ❑Yes ❑No

c. Has an assessment by a healthcare professional shown Esbriet to cause an improved sense of well-being in this patient? ❑Yes ❑No