Esbriet [pirfenidone]

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____**Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed medication? ❑ Ofev ❑ generic pirfenidone ❑ Esbriet
2. What is the diagnosis?
   ❑ Idiopathic pulmonary fibrosis (IPF) ❑ Other _____
3. What is the ICD-10 code? _____
4. 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, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes, *please specify:* _____
   ❑ No - Continue request for non-preferred product
5. 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
6. 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
7. 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 #9.*** ❑ Yes ❑ No
8. 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
9. Is this request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #11*
10. Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?
    ❑ Yes
    ❑ No, *no further questions.*
    ❑ Unknown

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Esbriet [pirfenidone] VF, ACSF SGM - 4/2023.

11. 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*.

12. 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 #16*

13. Please indicate what the HRCT scan demonstrates.
❑ Usual interstitial pneumonia (UIP) pattern, *no further questions*
❑ Other (e.g., probable UIP, indeterminate for UIP)

14. 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

15. 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.*

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

17. Please indicate what the biopsy report demonstrates.
❑ Usual interstitial pneumonia (UIP) pattern
❑ Other, please specify _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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