SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: pirfenidone (Esbriet®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

❑ Diagnosis: Idiopathic Pulmonary Fibrosis (IPF)

- ❑ Prescribed by or in consultation with a pulmonology specialist
- ❑ Member's diagnosis has been confirmed by:
  - ❑ Excluding any other causes of interstitial lung disease (i.e. environmental exposure, drug toxicity, and connective tissue disease)
  - ❑ High-resolution computed tomography (HRCT) revealing idiopathic fibrosis or probable IPF
  - ❑ IF IPF is not definitive, a lung biopsy has also been done to confirm IPF
- ❑ For initiating therapy:
  - ❑ Member's forced vital capacity (FVC) is measured to be 50 – 90% of the predicted value **(Please provide supporting documentation including a pulmonary function test (PFT) report and/or chart notes)**

(Continued on next page)

- ❑ Member's carbon monoxide (CO) diffusing capacity 30-90% of the predicted value **(Please provide supporting documentation including a pulmonary function test (PFT) report and/or chart notes)**

❑ No concomitant use of OFEV and pirfenidone **(**Esbriet)

Reauthorization: 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Continues to meet diagnostic criteria

❑ Member is **NOT** experiencing any of the following instances of toxicity from drug treatment:
- ❑ Liver toxicity performed at regular intervals; for female patients, periodic pregnancy test to rule out
- ❑ GI (D/N/V, perforation), arterial thromboembolic events
- ❑ Signs of photosensitivity

❑ Current state of disease and symptomology has been determined to be stable **(please provide supporting documentation that the disease has responded by reduction in the rate of decline in forced vital capacity (%FVC) compared to pre-treatment baseline)**

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****