Prescriber Criteria Form
Esbriet 2025 PA Fax 1217-A v1 010125.docx
Esbriet (pirfenidone), Pirfenidone
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-571** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Esbriet.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of idiopathic pulmonary fibrosis? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient currently receiving the requested drug? [If yes, then no further questions.]	Yes ◯	No ◯
3	Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy which shows the usual interstitial pneumonia (UIP) pattern? [If yes, then no further questions.]	Yes ◯	No ◯
4	Has the patient undergone a high-resolution computed tomography (HRCT) study of the chest which shows a result other than the usual interstitial pneumonia (UIP) pattern (e.g., probable UIP, indeterminate for UIP)? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the diagnosis of idiopathic pulmonary fibrosis been supported by a lung biopsy? [If yes, then no further questions.]	Yes ◯	No ◯
6	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 ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____