

# Esbriet (pirfenidone) Prior Authorization Form



WEST VIRGINIA DEPARTMENT OF

## HUMAN SERVICES

West Virginia Medicaid  
Bureau for Medical Services

Rational Drug Therapy Program  
WVU School of Pharmacy  
PO Box 9511 HSCN  
Morgantown, WV 26506  
Fax: 1-800-531-7787  
Phone: 1-800-847-3859



Patient Name (Last) (First) (M) WV Medicaid 11 Digit ID# Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) (First) (Credentials)

Prescriber Address (Street) (City) (State) (Zip)

Prescriber 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) (City) (State) (Zip)

Pharmacy 10-Digit NPI# Phone # (111-222-3333) Fax # (111-222-3333)

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**Important Notes:** Preauthorization for medical necessity does not guarantee payment.  
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name Strength Duration (if applicable) Route of Administration

**Esbriet (pirfenidone)**

Directions Diagnosis ICD Diagnosis Code (if available)

Does the patient have a diagnosis of Idiopathic Pulmonary Fibrosis (IPF)?	Yes	No - Not approved
Is the patient a smoker or a non-smoker?	Smoker	Non-smoker
If the patient is a smoker, has the patient enrolled in a smoking cessation program?	Yes	No - Not approved
Does the patient have End Stage Renal Disease (ESRD)?	Yes- Not approved	No
Is the patient on dialysis?	Yes- Not approved	No
Have liver function tests (ALT, AST and bilirubin) been conducted within the past six months?	Yes- Please attach	No- Not approved
Has the patient previously experienced greater than five times the upper limit of normal of ALT and/or AST while taking Esbriet (pirfenidone)?	Yes- Not approved	No

Other Pertinent Information (attach additional pages as needed)

**Attestation:** Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for  
electronic signature

Prescriber or Pharmacist Signature

Date:  
(MM/DD/YYYY)