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)

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

Updated 3/12/2026

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)