PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Esbriet - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Esbriet - Priority Partners MCO.

Drug Name (select from list of drugs shown)
ESBRIET (pirfenidone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 10.]

2.	Is the requested medication being prescribed for idiopathic pulmonary fibrosis (IPF)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Has the patient's diagnosis of idiopathic pulmonary fibrosis (IPF) been confirmed by all of the following: A) exclusion of other known causes of interstitial lung disease, such as domestic and occupational environmental exposures, connective tissue disease, drug toxicity, etc., and B) high resolution computerized tomography (HRCT) pattern, and surgical lung biopsy (if available) findings consistent with a diagnosis of IPF?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
4.	Have all of the following been submitted: A) baseline liver function tests (LFTs) within normal limits, B) baseline forced vital capacity (FVC) greater than or equal to 50 percent of predicted, C) baseline carbon monoxide diffusing capacity (DLCO) greater than or equal to 30 percent of predicted, and D) the patient has a low risk of any cardiovascular events?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Is the patient a female and of childbearing age?	Y N	
	[If no, skip to question 7.]		
6.	Does all of the following apply: A) verification of non-pregnant status prior to treatment initiation, and B) documentation that the patient will utilize two forms of birth control during treatment, and up to 3 months post-treatment?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Is the requested medication being prescribed by, or in consultation with, a pulmonologist?	Y N	
	[If no, no further questions.]		
8.	Is the patient 18 years of age or older?	Y N	
	[If no, no further questions.]		
9.	Does any of the following exclusions apply to the patient: A) patient is a current smoker, B) patient has severe hepatic impairment, C) patient has end-stage renal disease and is on dialysis?	Y N	
	[No further questions.]		
10.	Does all of the following apply: A) reduction in the annual rate of decline in forced vital capacity (FVC), and B) improvement of, or no worsening in, clinical symptoms?	Y N	

NOTE: Submission of medical records is required.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date