TRICARE Prior Authorization Request Form for
pirfenidone (Esbriet)

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: ______________________ Secure Fax #: ______________________

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Esbriet*	☐ Yes Proceed to question **6**	☐ No Proceed to question **2**
2. **Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Is the patient a smoker?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. **Is the patient being actively managed by a pulmonologist?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Is the patient also receiving therapy with Ofev?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
6. **Has the patient continued to refrain from smoking?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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Question	Yes	No
7. Is this renewal being submitted by a pulmonologist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient also receiving therapy with Ofev?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Has the patient experienced significant reduction in the annual rate of decline of forced vital capacity (FVC)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

__________________________________ ____________

Prescriber Signature Date

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: