TRICARE Prior Authorization Request Form for pirfenidone (Esbriet)



JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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.

Please complete patient and physician information (please print): Patient Name:							
Address: Sponsor ID #	Step	Please complete patient and physician information (please print):					
Sponsor ID # Date of Birth: Secure Fax #: Step Please complete the clinical assessment: 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 Esbnet 2. Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis? 3. Is the patient a smoker? 4. Is the patient being actively managed by a pulmonologist? 4. Is the patient being actively managed by a pulmonologist? 5. Is the patient also receiving therapy with Ofev? 6. Has the patient continued to refrain from smoking? Phone #: Secure Fax #: Proceed to question 6 Proceed to question 6 Proceed to question 3 STOP Coverage not approved A. Is the patient being actively managed by a pulmonologist? Proceed to question 5 STOP Coverage not approved 5. Is the patient also receiving therapy with Ofev? Proceed to question 7 STOP Coverage not approved 6. Has the patient continued to refrain from smoking? Proceed to question 7 STOP	.1	Patient Name:	Physiciar	n Name:			
Date of Birth: Secure Fax #:		Address:	Address:				
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		6. Has the patient continued to refrain from smoking	?	□ Yes	□ No		
Cov erage not approved				Proceed to question 7	STOP		
					Coverage not approved		

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