US Family Health Plan
Prior Authorization Request Form for
pirfenidone **(Esbriet)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization will expire after one year.
For renewal of therapy an initial USFHP prior authorization approval is required. **usfamilyhealth.org/rx-pa**

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:**

1. Has the patient received this medication under the USFHP/ 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**

Continue on next page

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