IPF, Fibrosing ILD and SSc-ILD Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-506-5276
Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____Address: _____City, State, ZIP: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____DOB: _____ Gender: ☐ Male ☐ Female

Email: _____Last Four of SSN: _____Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ J84.112 Idiopathic Pulmonary Fibrosis ☐ J84.10 Pulmonary Fibrosis, Unspecified

☐ M34 Systemic Sclerosis ☐ J84.170 Interstitial Lung Disease with a progressive fibrotic phenotype

☐ M34.81 Systemic Sclerosis with lung involvement ☐ Other Code: _____ Description _____

*Esbriet (pirfenidone) is only indicated for IPF

Prior Therapy: ☐ Yes, current or most recent therapy: _____ ☐ No Prior Therapies

Patient Clinical Information:

Is patient on oxygen therapy? ☐ Yes ☐ No

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Esbriet (pirfenidone)	☐ 267 mg capsule ☐ 267 mg tablet	☐ Initial Titration Order Directions: Days 1 through 7: Take one capsule/tablet by mouth three times daily with food Days 8 through 14: Increase to two capsules/tablets by mouth three times daily with food Day 15 and onward: Increase to three capsules/tablets three times daily with food ☐ Maintenance Order: Take three capsules/tablets by mouth three times daily with food ☐ Other: _____	Quantity: 270 (30-day supply) Refills: _____
☐ Esbriet (pirfenidone)	801 mg tablet (for maintenance dose)	Maintenance Dose: Take one tablet (801 mg) by mouth three times daily with food	Quantity: 90 tablets (30-day supply) Refills:_____
☐ Ofev (nintedanib)	☐ 150 mg capsule ☐ 100 mg capsule	☐ Take one capsule by mouth every 12 hours as directed with food. ☐ Other: _____	Quantity: 60 capsules (30-day supply) Refills:_____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.