IPF, Chronic 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: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
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)

Is the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone:_____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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
☐ 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

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Patient Address:_____
Prescriber Name: _____ Prescriber Phone: _____

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: 207 (30-day supply) Refills: 0 ☐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:_____
☐ Pirfenidone	☐ 267 mg tablet	☐ Initial Titration Order Directions: Days 1 through 7: Take one tablet by mouth three times daily with food Days 8 through 14: Increase to two tablets by mouth three times daily with food Day 15 and onward: Increase to three tablets three times daily with food ☐ Maintenance Order: Take three tablets by mouth three times daily with food ☐ Other: _____	☐Quantity: 207 (30-day supply) Refills: 0 ☐Quantity: 270 (30-day supply) Refills: _____
☐ 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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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.