

# IPF, Fibrosing ILD and SSC-ILD Enrollment Form



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
<input type="checkbox"/> Esbriet (pirfenidone)	<input type="checkbox"/> 267 mg capsule <input type="checkbox"/> 267 mg tablet	<input type="checkbox"/> 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 <input type="checkbox"/> Maintenance Order: Take three capsules/tablets by mouth three times daily with food <input type="checkbox"/> Other: _____	Quantity: 270 (30-day supply) Refills: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> Ofev (nintedanib)	<input type="checkbox"/> 150 mg capsule <input type="checkbox"/> 100 mg capsule	<input type="checkbox"/> Take one capsule by mouth every 12 hours as directed with food. <input type="checkbox"/> 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)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_

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.

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