

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Pirfenidone**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:		Prescriber Name:	
Member Number:		Fax: Phone:	
Date of Birth:		Office Contact:	
Line of Business: □ Exchange - PA		NPI: State Lic ID:	
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	
	<u>DITED REVIEW</u> : By checking this box and signing below lee's ability to regain maximum function.	ow, I certify that the standard review timeframe may seriously jeopardize the life or health	
Drug Name:			
Strength:			
Directions / SIG:			
Please attach any pertinent medical history including labs and information for this member that may support approval.  Please answer the following questions and sign.			
Q1. Is the patient currently being treated with pirfenidone for the treatment of idiopathic pulmonary fibrosis (IPF)?			
☐ Yes		□ No	
Q2. Is there documentation of rationale for continued therapy (e.g., stability or improvement in the rate of decline for FVC, IPF symptoms, or other prescriber-assessed benefit of therapy)?			
☐ Yes		□ No	
Q3. Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by: usual interstitial pneumonia (UIP) pattern present on high resolution computed tomography (HRCT) in patients without lung biopsy, or the combination of HRCT and biopsy pattern in patients with lung biopsy?			
☐Yes		□ No	
environmenta	al exposures, connective tissue d	ng disease (ILD) (e.g., domestic and occupational lisease, drug toxicity, Hermansky-Pudlak syndrome, onic hypersensitivity pneumonitis) been excluded?	

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Patient Name:	Prescriber Name:		
☐ Yes	□ No		
Q5. Does the patient have a documented forced 50%?	vital capacity (FVC) greater than or equal to		
☐ Yes	□ No		
Q6. Are documented liver function tests (ALT, AST, and bilirubin) attached?			
□ Yes	□ No		
Q7. Is the patient 18 years of age or older?			
☐ Yes	□ No		
Q8. Is pirfenidone being prescribed by or in consultation with a pulmonologist?			
☐ Yes	□ No		
Q9. Are liver function tests (ALT, AST, and bilirubin) being monitored periodically throughout the course of treatment as clinically indicated?			
□Yes	□ No		
Q10. Additional Information:			
Prescriber Signature	Date		
	2024 Prior Authorization Request		

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