**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Esbriet (pirfenidone) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 12 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Esbriet (pirfenidone).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

## 1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

## 2 – Provider Information

Is the prescriber a pulmonologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

## 3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

## 4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

## 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

**Clinical Criteria:**

1. If ordering brand Esbriet, patient has tried and failed prior use of pirfenidone (generic Esbriet),
   □ No □ Yes

2. **AND** member is a non-smoker,
   □ No □ Yes

3. **AND** member is not receiving concomitant treatment with nintedanib or any CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin),
   □ No □ Yes

4. **AND** using for one of the following diagnoses:
   - Idiopathic pulmonary fibrosis (IPF):
     - NO known cause of interstitial lung disease

   □ No □ Yes

   - OR diagnosis of systemic sclerosis associated with interstitial lung disease (SSc-ILD) with greater than or equal to 10% fibrosis on a chest HRCT scan (conducted within last 12 months)

   □ No □ Yes

**For continuation of therapy, please respond to <u>additional questions</u> below:**

1. Member continues to meet initial criteria with positive clinical response,
   □ No □ Yes

2. **AND** hepatic function and spirometry are monitored at least annually,
   □ No □ Yes

3. **AND** member continues to be under the care of a pulmonologist
   □ No □ Yes

**6 – Provider Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Provider Signature:** | **Date:** |
|---|---|
| | |