

IPF, Chronic Fibrosing ILD and SSc-ILD Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

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: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

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)

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

IPF, Chronic Fibrosing ILD and SSc-ILD Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____

Patient DOB: _____

Prescriber Name: _____

Prescriber Phone: _____

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: _____	<input type="checkbox"/> Quantity: 207 (30-day supply) Refills: 0 <input type="checkbox"/> Quantity: 270 (30-day supply) Refills: _____
		Maintenance Dose: Take one tablet (801 mg) by mouth three times daily with food	Quantity: 90 tablets (30-day supply) Refills: _____
<input type="checkbox"/> Pirfenidone	<input type="checkbox"/> 267 mg tablet	<input type="checkbox"/> 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 <input type="checkbox"/> Maintenance Order: Take three tablets by mouth three times daily with food <input type="checkbox"/> Other: _____	<input type="checkbox"/> Quantity: 207 (30-day supply) Refills: 0 <input type="checkbox"/> Quantity: 270 (30-day supply) Refills: _____
		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 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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