

# IPF, Fibrosing ILD and SSc-ILD Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com

Address: 280 Avenida Jesus T. Pintero Ste B Rio Piedras, PR 00927

## 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

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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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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