

<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Name (Last)	(First)	(MI)	Prescriber Specialty
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Name (if applicable)
<input type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Confidentiality Notice:** This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.

**Important Notes:** Preauthorization for medical necessity does not guarantee payment.  
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name	Strength	Route of Administration
ESBRIET® (perfenidone)	<input type="text"/>	<input type="text"/>
Directions	Diagnosis	ICD Diagnosis Code (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Does the patient have a diagnosis of idiopathic pulmonary fibrosis (IPF)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not approved
Is the patient eighteen (18) years of age or older?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not approved
Has the patient enrolled in a smoking cessation program , or does not smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - Not approved
Does the patient have End Stage Renal Disease (ESRD) or is on dialysis?	<input type="checkbox"/> Yes- Not approved	<input type="checkbox"/> No
Has the patient previously been treated with Esbriet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, did the patient experience greater than five (5) times the upper normal limit of ALT and/or AST?	<input type="checkbox"/> Yes- Not approved	<input type="checkbox"/> No
Have liver function tests (ALT, AST and bilirubin) been conducted within the past six months?	<input type="checkbox"/> Yes - Documentation must be submitted	<input type="checkbox"/> No - Not approved

Other Pertinent Information (attach additional pages as needed)

**Attestation:** Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for electronic signature

Prescriber of Pharmacist Signature		Date: (MM/DD/YYYY)	
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