West Virginia Medicaid
Drug Prior Authorization Form

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

Esbriet® Prior Authorization Form

(perfenidone)

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI) | Prescriber Specialty

Prescriber Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

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: ESBRIET® (perfenidone) | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

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