STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

ESBRIET® (perfenidone)

Prior Authorization Request Form

ESBRIET is indicated for the treatment of idiopathic pulmonary fibrosis (IPF).

Criteria for Approval

1) Diagnosis of idiopathic pulmonary fibrosis (IPF); **AND**
2) Must be prescribed by or in conjunction with a pulmonologist; **AND**
3) Patient must be eighteen (18) years of age or older; **AND**
4) Patient must be enrolled in a smoking cessation program (or must indicate that they do not smoke); **AND**
5) Liver function tests (ALT, AST, and bilirubin) should be conducted prior to the initiation of therapy, then monthly for the first six (6) months and every three (3) months thereafter. Lab results must be submitted with prior authorization request; **AND**
6) Patient must not have ESRD or be on dialysis.

Note:

- Patient will be denied coverage if they have previously been treated with Esbriet and experienced greater than five (5) times the upper normal limit of ALT and/or AST.
- Esbriet is pregnancy category C; caution is advised when considering use in pregnant patients.

References

1) Esbriet package insert 10/28/2014
2) Lexi-Comp Clinical Application 11/26/2014
3) http://medlibrary.org/lib/rx/meds/esbriet/

Version 1 – DUR Board reviewed and approved (2-25-2015)
Version 1.1 – created 03-09-2015 (BMT)