

Esbriet[®] & Ofev[®] Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:			
Street Address:	Office Fax:					
City:	State:	Zip:	Office Street Address:			
Phone:			City:	State:		Zip:
Medication Information (required)						
Medication Name:			Strength:		Dosage Form:	
Check if requesting	brand	Directions for Use:				
Check if request is						
Clinical Information (required)						
Select the diagnosis below:						
Other diagnosis: ICD-10 Code(s):						
Clinical informatio	n:					
Does the patient have a forced vital capacity (FVC) greater than or equal to 50% of predicted in the last 60 days? D Yes D No						
Is the requested medication prescribed by or in consultation with a pulmonologist? U Yes D No						

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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