Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Pirfenidone

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient currently being treated with pirfenidone for the treatment of idiopathic pulmonary fibrosis (IPF) or is this a reauthorization request? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there documentation of rationale for continued therapy (e.g., stability or improvement in the rate of decline for FVC, IPF symptoms, or other prescriber-assessed benefit of therapy)? If YES, go to 7.

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by: usual interstitial pneumonia (UIP) pattern present on high resolution computed tomography (HRCT) in patients without lung biopsy, or the combination of HRCT and biopsy pattern in patients with lung biopsy? If YES, go to 4.

☐ Yes ☐ No

Q4. Have other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity, Hermansky-Pudlak syndrome, familial idiopathic pulmonary fibrosis, and chronic hypersensitivity pneumonitis) been excluded? If YES, go to 5.

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Member Name:	**Prescriber Name:**

☐ Yes ☐ No

Q5. Are documented baseline liver function tests (ALT, AST, and bilirubin) attached? If YES, go to 6.

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older? If YES, go to 7.

☐ Yes ☐ No

Q7. Is pirfenidone being prescribed by or in consultation with a pulmonologist? If YES, go to 8.

☐ Yes ☐ No

Q8. Are liver function tests (ALT, AST, and bilirubin) being monitored periodically throughout the course of treatment as clinically indicated?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026