Genentech | Access Solutions
A Member of the Roche Group
for Esbriet® (pirfenidone)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) M-US-00006690(v3.0)

Step 1 Patient Information

*First name: _____ *Last name: _____

*Date of birth (MM/DD/YYYY): ____/____/____ Gender: ☐ Male ☐ Female

Street: _____ Apt: _____

City: _____ *State: _____ ZIP: _____

Home phone: (____) ____-____ Cell phone: (____) ____-____ ☐ Do not contact patient

Alternate contact name: _____ Relationship: _____ Alt. phone: (____) ____-____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____ Has patient started therapy? ☐ Yes ☐ No

Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No

If patient is uninsured, please complete the Prescriber Foundation Form or call (888) 941-3331 for assistance.

If insured, please fill out the information below or attach a copy of the patient's insurance cards.

Is prior authorization in place? ☐ Yes ☐ No Auth #: _____

	Primary Insurance	Secondary Insurance
Insurance name		
Subscriber name (if not patient)		
Subscriber/Policy ID #		
Group #		
Insurance phone		

Step 3 Diagnosis

*To the highest level of specificity, provide primary diagnosis code: ☐ J84.112 Idiopathic pulmonary fibrosis ☐ Other code: _____

Step 4 Clinical Information

Must Select Initial Tablet Titration and Maintenance Tablet Dose for New Patients.

*Initial Tablet Titration ☐ Esbriet 267 mg 30-day supply (207 tablets)

Treatment Days	Dosing Instruction From PI
Days 1-7	1 tablet by mouth 3 times/day with meals
Days 8-14	2 tablets by mouth 3 times/day with meals
Days 15+	3 tablets by mouth 3 times/day with meals

*Maintenance Tablet Dose

☐ Esbriet 267 mg 30-day supply (270 tablets) _____ refills
Directions: 3 tablets by mouth 3 times/day with meals

☐ Esbriet 801 mg 30-day supply (90 tablets) _____ refills
Directions: 1 tablet by mouth 3 times/day with meals

If selecting 801 mg maintenance dose, please ensure the patient is currently tolerating 267 mg (3 doses by mouth 3 times/day with meals)

Other special instructions: _____

Preferred specialty pharmacy: _____

Step 5 Prescriber Information

*First name: _____ *Last name: _____

*Practice name: _____

*Street: _____ Suite: _____ *City: _____

*State: _____ *ZIP: _____ Prescriber tax ID #: _____

Prescriber NPI† #: _____ Group NPI† #: _____

Office contact: _____ Contact phone: (____) ____-____ Contact fax: (____) ____-____

Step 6 Start Now Program (signature required)

☐ I approve the dispense of up to a 30-day free supply of Esbriet 267 mg to my patient if they experience an insurance coverage delay and otherwise meet eligibility criteria. For full eligibility criteria, please visit Genentech-Access.com/Esbriet or speak to your Esbriet representative.

Step 7 Health Care Provider Certification

By submitting this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician. (b) If the indication for which this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use. (c) The provider's office received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome. (d) The provider's office will not attempt to seek reimbursement for free product provided to the patient. (e) The services requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA) and appeals support, co-pay card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

Sign, date & fax to **(844) 372-7444**

Prescriber's Signature: _____ **Date:** ____/____/____
(Original or stamped signature required)

†National Provider Identifier.