

Esbriet Prescription Form

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

SUBMIT ONLY REQUESTED DOCUMENTS

M-US-00020950(v1.0)

Step 1 Patient Information

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First name:					_Last name	2:					
Date of birth (MM/DE)/YYYY):	/	/		_Gender:	Male	Female				
Street:								Apt	:		
City:							_State:	ZIP:			
Home phone: ()	-		_Cell phone:	()	-			Do not con	tact patie	nt
Alternate contact na	me:			_Relationship):		_ Alt. phone: ()	-		_
Preferred language:	English	Spanish	Other:				_ Has patient star	ted thera	apy? Ye	es No)
Step 2	Insurance Ir	nformation									
		_									

Please fill out the information below or attach a copy of the patient's insurance card(s).

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 Complete Prescription for Esbriet

To the highest level of specificity, provide primary diagnosis code: J84.112 Idiopathic pulmonary fibrosis Other code: Must Select Initial Tablet Titration and Maintenance Tablet Dose for New Patients: **INITIAL TABLET TITRATION** MAINTENANCE TABLET DOSE

Esbriet 267-mg 30-day supply (207 tablets)

Treatment Days	Dosing Instruction From PI	Directions: 3 tablets by mouth 3 times/day with meals Esbriet 801-mg 30-day supply (90 tablets) refills
Days 1-7	1 tablet by mouth 3 times/day with meals	Directions: 1 tablet by mouth 3 times/day with meals
Days 8-14	2 tablets 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)
Days 15+	3 tablets by mouth 3 times/day with meals	Other special instructions:

NKDA Known drug allergies: _____

Concurrent medications: _

Step 4

Prescriber Information

First name:		Last name:					
Practice name:							
State:	ZIP:	Prescriber tax ID #: _					
Prescriber NPI*	#:	Group NPI* #:					
Office contact:	Contact phone: () -	Contact fax: ()	-		
SIGN AND DATE HERE	Prescriber Authorization [†] Prescriber's Signature	(Brand Necessar		ate:	/	/	
	Prescriber Authorization [†] Prescriber's Signature	(Substitution Permi		ate:	/	/	
By your acknowled	gment and signature above, an authorization is provided to disper	use the prescription					

*National Provider Identifier.

*Signature stamps not acceptable. If required by applicable law, please attach copies of all prescriptions on official state prescription forms. Prescription is valid only if received by fax.

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ESBRIET PRESCRIPTION FORM INSTRUCTIONS —

Guide to completing the prescription form

for Est	e)			Esbriet Prescription Fo SUBMIT ONLY REQUESTED DOCUM
Step 1	Patient Inform			
First name:			Last name:	
		1 1	Gender: 🗌 Ma	
Street:				Apt:
City:				State:ZIP:
		Cell pho		
Alternate contact				Alt. phone: () -
Preferred languag	e: 🗌 English 📋	Spanish Other:		Has patient started therapy? Yes
Step 2	Insurance Info	ormation		
Please fill out the	information belo	w or attach a copy of the pai	tient's insurance car	d(s)
		/es No Auth#:		0(5)
is prior dutionizati		Primary Ins		Secondary Insurance
Insurance name				
Subscriber name	(if not patient)			
Subscriber/Policy				
Group #	,			
Insurance phone				
		and Maintenance Tablet Dos	e for New Patients:	
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CHECK ITEMS UPON COMPLETION Step 1 Patient Information Step 2 Insurance Information Step 3 Complete Prescription for Esbriet Step 4 Prescriber Information & Signature (NOTE: Omission of signature will result in processing delays.) Step 5 Fax the COMPLETED Prescription Form directly to your preferred specialty pharmacy. Do not fax to Genentech Access Solutions.

Esbriet product access is no longer limited to specific specialty pharmacies.

Thank you for completing the Esbriet Prescription Form.

Additional forms can be found at

https://www.esbriethcp.com/resources/practice-forms-and-documents.html.