Genentech
A Member of the Roche Group

for Esbriet®
(pirfenidone)

Esbriet Prescription Form

SUBMIT ONLY REQUESTED DOCUMENTS

M-US-00020950(v1.0)

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

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

☐ 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:** _____

☐ NKDA ☐ Known drug allergies: _____

Concurrent medications: _____

Step 4 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: (____) ____-____

SIGN AND DATE HERE

Prescriber Authorization† Prescriber's Signature _____ Date: ____/____/____
(Brand Necessary)

Prescriber Authorization† Prescriber's Signature _____ Date: ____/____/____
(Substitution Permitted)

By your acknowledgment and signature above, an authorization is provided to dispense 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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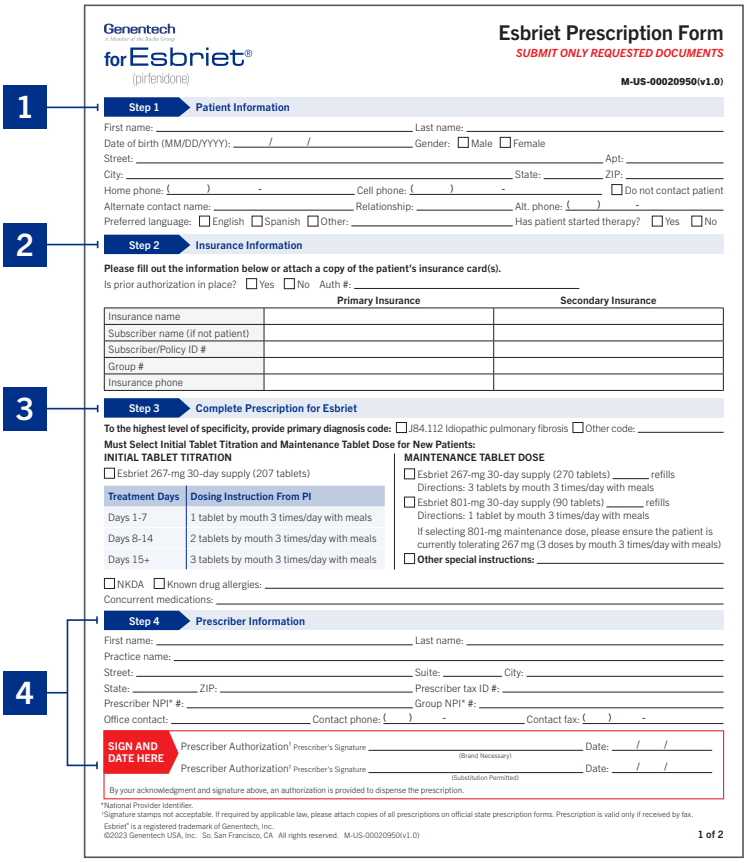
ESBRIET PRESCRIPTION FORM INSTRUCTIONS —
Guide to completing the prescription form



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1 **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

2 **Step 2 Insurance Information**

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		

3 **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
☐ Esbriet 267-mg 30-day supply (207 tablets)

Treatment Days	Dosing Instruction From PI
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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:** _____

☐ NKDA ☐ Known drug allergies: _____
Concurrent medications: _____

4 **Step 4 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: (___) ___-___

SIGN AND DATE HERE
Prescriber Authorization† Prescriber's Signature _____ (Brand Necessary) Date: ___/___/___
Prescriber Authorization† Prescriber's Signature _____ (Substitution Permitted) Date: ___/___/___
By your acknowledgment and signature above, an authorization is provided to dispense the prescription.

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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.
