

Esbriet Prescription Form

SUBMIT ONLY REQUESTED DOCUMENTS

M-US-00020950(v1.0)

Step 1	Patient Information			
		Last name:		
	//DD/YYYY):			
				Apt:
	Cell ph			
Alternate contact	t name: Relation	nship:	Alt. phone:	
Preferred langua	ge: English Spanish Other:		Has patient start	ed therapy? Yes No
Step 2	Insurance Information			
	e information below or attach a copy of the pation in place? Yes No Auth #:			
Inquirance name	Primary Ins	urance	Secon	dary Insurance
Insurance name				
Subscriber/Polic	:y IU #			
Group #				
Insurance phone				
Step 3	Complete Prescription for Esbriet			
Must Select Initia		se for New Patients: MAINTENANCE TA	BLET DOSE	
☐ Esbriet 267-m	g 30-day supply (207 tablets)		30-day supply (270 tak	
Treatment Days	Dosing Instruction From PI	Esbriet 801-mg 3	lets by mouth 3 times/ 30-day supply (90 tabl	ets) refills
Days 1-7	1 tablet by mouth 3 times/day with meals		let by mouth 3 times/c	*
Days 8-14	2 tablets by mouth 3 times/day with meals	_	_	, please ensure the patient is mouth 3 times/day with meals)
Days 15+	3 tablets by mouth 3 times/day with meals		-	
□NKDA □ Kn	own drug allergies:			
	cations:			
Step 4	Prescriber Information			
First name:		Last name:		
Practice name: _				
Street:		Suite:	City:	
State:	ZIP:	Prescriber tax ID	#:	
	! :			
Office contact:	Contact phone: _		Contact fax: _	
SIGN AND	Prescriber Authorization [†] Prescriber's Signature			Date:
DATE HERE		(Brand Ned	cessary)	Date:
	Prescriber Authorization [†] Prescriber's Signature	(Substitution	Permitted)	Jale:
By your acknowledge	ment and signature above, an authorization is provided to disp	pense 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

Genentech A Monter of the Anche Group for Est (pirfenido)	oriet®	Esbriet Prescription Form SUBMIT ONLY REQUESTED DOCUMENTS	CHECK ITEMS UPON COMPLETION
(pir ierildoi	le)	M-US-00020950(v1.0)	
Step 1	Patient Information		Cton 1 Detient Information
rst name:	//DD/YYYY):/_/	Last name: Gender: Male Female	Step 1 Patient Information
et:	, , , , , , , , , , , , , , , , , , ,	Apt:	
y: me phone: () - Cell ph	State:ZIP:	
rnate contac			
ferred langua	ge: English Spanish Other:	Has patient started therapy? Yes No	Step 2 Insurance Information
Step 2	Insurance Information		
ase fill out th	e information below or attach a copy of the pa	tient's insurance card(s).	
prior authoriza	tion in place? Yes No Auth #:	<u> </u>	
surance name	Primary In:	surance Secondary Insurance	Step 3 Complete Prescription for Esbriet
	e (if not patient)		
Subscriber/Poli	cy ID #		
Group # nsurance phon	0		
Step 3 the highest le	Complete Prescription for Esbriet vel of specificity, provide primary diagnosis code	e: ☐ J84.112 Idiopathic pulmonary fibrosis ☐ Other code:	Step 4 Prescriber Information & Signatu
to the highest let flust Select Initi NITIAL TABLET Esbriet 267-m Treatment Days Days 1-7 Days 8-14	vel of specificity, provide primary diagnosis code ial Tablet Titration and Maintenance Tablet Do		(NOTE: Omission of signature will result in processing delays.)
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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.