Orsini
Rare Disease Pharmacy Solutions

THERAPY	PHONE	FAX
Esbriet and Pirfenidone	800.355.9366	877.358.9246
Jascayd	847.239.5646	847.423.6217
OFEV and Nintedanib	800.373.1452	888.975.1456

PATIENT ENROLLMENT: ESBRIET, JASCAYD, NINTEDANIB, OFEV, AND PIRFENIDONE

1 PATIENT INFORMATION *(Please complete the following information)*

☐ **Please attach demographic information**

Patient Name (First, MI, Last): _____ DOB: _____ Gender: ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip: _____

Patient Phone Number: _____ Email: _____

Parent/Caregiver Name (First, MI, Last): _____ Parent/Caregiver Phone Number: _____

2 INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.**

Primary Insurance Name: _____

Primary Insurance ID: _____

Insurance Phone Number: _____

Policyholder Name: _____

Secondary Insurance Name: _____

Phone: _____ Subscriber Name: _____

Subscriber ID #: _____

Group #: _____

3 DIAGNOSIS INFORMATION

☐ **Please fax clinical documentation to pharmacy along with referral form.**

☐ (J84.112) Idiopathic pulmonary fibrosis ☐ (M34.81) Systemic Sclerosis with Lung Involvement ☐ (J84.10) Pulmonary Fibrosis, Unspecified

☐ (J84.170) Interstitial lung disease with a progressive fibrotic phenotype in diseases classified elsewhere ☐ Other (ICD-10): _____

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Tax ID #: _____ Prescriber NPI #: _____ Group NPI #: _____

Office Contact: _____ Office Contact Phone: _____ Fax: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY & REFILLS
☐ Esbriet (pirfenidone)	◯ 267mg capsule ◯ 267mg tablet	☐ **Initial Titration Order Directions:** Days 1 through 7: Take one capsule/tablet by mouth three times daily with food Days 8 through 14: Take two capsules/tablets by mouth three times daily with food Day 15 and onward: Take three capsules/tablets by mouth three times daily with food	☐ Qty: 207 (30 day supply) Refills: 0
		☐ Maintenance Order: Take three capsules/tablets by mouth three times daily with food ☐ Other: _____	☐ Qty: 270 (30 day supply) Refills: ____ ☐ Other Qty: _____ (30 day supply) Refills: ____
☐ Esbriet (pirfenidone)	801mg tablet (for maintentance dose)	Maintenance Dose: Take one tablet (801mg) by mouth three times daily with food	◯ Qty: 90 (30 day supply) Refills: ____
☐ Jascayd (nerandomilast)	◯ 9mg tablet ◯ 18mg tablet	◯ Take one capsule by mouth twice per day ◯ Other: _____	◯ Qty: 60 (30 day supply) Refills: ____ ◯ Other Qty: _____ (30 day supply) Refills: ____
☐ Nintedanib ☐ Nintedanib (Dexcel NDC DAW1)*	◯ 150mg capsule ◯ 100mg capsule	◯ Take one capsule by mouth every 12 hours as directed with food ◯ Other: _____	◯ Qty: 60 (30 day supply) Refills: ____ ◯ Other Qty: _____ (30 day supply) Refills: ____
☐ Ofev (nintedanib)	◯ 150mg capsule ◯ 100mg capsule	◯ Take one capsule by mouth every 12 hours as directed with food ◯ Other: _____	◯ Qty: 60 (30 day supply) Refills: ____ ◯ Other Qty: _____ (30 day supply) Refills: ____
☐ Pirfenidone	◯ 267mg capsule ◯ 267mg tablet	☐ **Initial Titration Order Directions:** Days 1 through 7: Take one capsule/tablet by mouth three times daily with food Days 8 through 14: Take two capsules/tablets by mouth three times daily with food Day 15 and onward: Take three capsules/tablets by mouth three times daily with food	☐ Qty: 207 (30 day supply) Refills: 0
		☐ Maintenance Order: Take three capsules/tablets by mouth three times daily with food ☐ Other: _____	☐ Qty: 270 (30 day supply) Refills: ____ ☐ Other Qty: _____ (30 day supply) Refills: ____
☐ Pirfenidone	801 mg tablet (for maintentance dose)	Maintenance Dose: Take one tablet (801mg) by mouth three times daily with food	◯ Qty: 90 (30 day supply) Refills: ____

6 PHYSICIAN SIGNATURE (Required)

***Note:** Please sign under Dispense as Written below if this option is selected.

X _____ _____ X _____ _____

PRODUCT SUBSTITUTION PERMITTED — DATE OF SIGNATURE — DISPENSE AS WRITTEN — DATE OF SIGNATURE

The prescriber is to comply with applicable state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with states-specific requirements could result in outreach to the prescriber. **ATTN: New York and Iowa prescribers, please submit electronic prescriptions.**