

# PIRFENIDONE PATIENT ENROLLMENT

**1 PATIENT INFORMATION**  Please attach demographic information  
*(Please complete the following 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.

<b>Primary Insurance Name:</b> _____ Primary Insurance ID: _____ Insurance Phone Number: _____ Policyholder Name: _____	<b>Secondary Insurance Name:</b> _____ Phone: _____ Subscriber Name: _____ Subscriber ID #: _____ Group #: _____
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**3 DIAGNOSIS INFORMATION**  Please fax clinical documentation to pharmacy along with referral form.

Idiopathic pulmonary fibrosis (J84.112) (ICD-10-CM)  Other (ICD-10 Code): \_\_\_\_\_

**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**

**Initial Tablet Titration**

Pirfenidone 267 mg 30-day supply (207 tablets)

Treatment Days	Dosing Instructions from PI
Days 1-7	1 tablet by mouth 3x/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

Other Special Instructions: \_\_\_\_\_

**Maintenance Tablet Dose**

Pirfenidone 267 mg 30-day supply (270 tablets) \_\_\_\_\_ Refills  
 Directions: 3 tablets by mouth 3x/day with meals

Pirfenidone 801 mg 30-day supply (90 tablets) \_\_\_\_\_ Refills  
 Directions: 1 tablet by mouth 3x/day with meals

**6 PRESCRIBER SIGNATURE**

Physician's Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.