For assistance, contact your pharmacy representative: _____ Phone:_____**(For providers only)**

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

IPF

Prescription/Pharmacy Intake Form

Pharmacy: _____
Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____
ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____
Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____
Primary Diagnosis Code and Condition (ICD-10): ☐J84.112 ☐Other Diagnosis/Conditions: _____ Date of Diagnosis: _____
Oxygen use: ☐Yes ☐No Other Therapies Tried & Failed (Please List): _____
Allergies: _____

PRESCRIPTION INFORMATION

Medication	Directions/Frequency	Quantity	Refills
Esbriet ☐267mg Capsules Titration Pack			
Esbriet ☐267mg Tablets ☐267mg Capsules ☐801mg Tablets			
Ofev ☐150mg Capsules ☐100mg Capsules			
☐Other: _____			

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written
_____ Substitution permitted
_____ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.