



IDIOPATHIC PULMONARY FIBROSIS TREATMENT REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation Bldg.
St. John's, NL A1B 4J6

Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
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Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number
Address		

Drug Requested

<input type="checkbox"/> Esbriet® (pirfenidone) 267 mg capsules	<input type="checkbox"/> Ofev® (nintedanib) 150 mg capsules
	<input type="checkbox"/> Ofev® (nintedanib) 100 mg capsules
<input type="checkbox"/> Initial request: Is the patient currently on Esbriet/Ofev?	<input type="checkbox"/> Renewal request (Skip to Renewal Information Section)
<input type="checkbox"/> Yes : Start date _____	
<input type="checkbox"/> No	

Dose Requested

Expected start date	Duration of therapy
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Clinical Information

- What is the patient's diagnosis for which Esbriet/Ofev is being requested for funding consideration?
 - Idiopathic Pulmonary Fibrosis (IPF)
 - Other (Please specify): _____
- Diagnosis confirmation: (If the requesting physician is not the diagnosing Respiriologist, please also submit a Respiriology consultation note that supports the diagnosis of IPF)
 - IPF confirmed by Respiriologist: Yes No
Name/Location: _____ Date: _____
 - IPF confirmed by HRCT Scan: Yes No Date: _____
[Submit a copy of the initial HRCT scan report (with interpretation section) used to confirm IPF]
 - All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) have been excluded. Yes No
- Pulmonary Function Tests (PFTs):

		Date Measured (DD-MM-YYYY)	Percent (%) Predicted Result
Forced Vital Capacity (FVC) (% Predicted)	Before Initiation of Esbriet/Ofev treatment (baseline pre-treatment)		
	And on Esbriet/Ofev (if applicable)		

Renewal Information

Start Date of Esbriet/Ofev therapy (DD-MM-YYYY):			
Pulmonary Function Tests (PFTs)		Date Measured (DD-MM-YYYY)	Percent (%) Predicted Result
Previous Forced Vital Capacity (FVC) (% Predicted)	Baseline Pre-treatment or within the past 12 months, as applicable		
Most recent Forced Vital Capacity (FVC) (% Predicted)	Most recent Forced Vital Capacity (FVC) (% Predicted) on Esbriet		
Confirmatory Forced Vital Capacity (FVC) on Esbriet/Ofev (% Predicted)	Confirmatory PFT conducted 4 weeks later if there is an absolute decline in the percent predicted FVC of $\geq 10\%$ since initiation of therapy (baseline pre-treatment) or within 12 months since last PFT, as applicable.		

Prescriber Information/Requested by:

Prescriber Name: _____ License Number: _____ Phone Number: _____
 Address: _____ Fax Number: _____
 Signature: _____ Date: _____