Mass General Brigham
Health Plan

Esbriet (pirfenidone)
pirfenidone (generic)
Effective 01/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	These medications have been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview

FDA-Approved Indication

Esbriet/pirfenidone is indicated for the treatment of idiopathic pulmonary fibrosis (IPF).

All other indications are considered experimental/investigational and not medically necessary.

Coverage Guidelines

Authorization may be granted for members new to the plan who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for treatment of idiopathic pulmonary fibrosis when the member has undergone a diagnostic work-up which includes the following:

A. Other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) have been excluded AND
B. The member has completed a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy which reveals a result consistent with the usual interstitial pneumonia (UIP) pattern OR has completed an HRCT study of the chest which reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP, alternative diagnosis) and the diagnosis is supported by a lung biopsy. If a lung biopsy has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in IPF.

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy for an indication listed above may be granted an authorization when the member is currently receiving treatment with the requested medication.

Limitations

1. Approvals will be granted for 12 months.

References

1. Esbriet [package insert]. South San Francisco, CA: Genentech USA, Inc.; February 2022.
2. Pirfenidone [package insert.] Berkeley Heights, NJ: Laurus Labs Limited; February 2022.
3. Raghu G, Remy-Jardin M, Richeldi L, et al. Idiopathic Pulmonary Fibrosis (an Update) and Progressive Pulmonary Fibrosis in Adults: An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline. Am J Respir Crit Care Med. 2022;205(9):e18-e47. doi:10.1164/rccm.202202-0399ST

Review History

12/13/2023: Reviewed at Dec P&T, switched from SGM to Custom. Effective 1/1/2024