AccessLink
a BioScript Solutions system

Tel: 1-888-398-0028 | Fax: 1-855-278-5182

Pirfenidone Prescription Form

Patient Information

Full Name: ______________________________

Date of Birth (DD/MM/YYYY): ____/____/______

OR affix patient label here

Address: ____ **City:** ________________ **Prov.:** _______ **Postal Code:** __________

Home #: _________________________ **Cell #:** _______________________________ **Email:** ____

Preferred Contact Time: ☐ **Daytime** ☐ **Evening** ☐ **Anytime**

Health Card #: ____ **Allergies:** ____

Insurance Information: ☐ **Public Coverage** ☐ **Private Coverage**

Insurance Company: ______________________ **Plan Member:** ______________________ **Relationship:** _______________________

Carrier #: ______________ **Contract/Group #:** _________________ **Client/Plan #:** ____

Physician Information

Name: ____ **Specialty:** _________________ **License #:** ____________________________

Address: ____ **City:** ________________ **Prov.:** _______ **Postal Code:** __________

Phone #: __________________________ **Fax #:** ________________________________ **Email:** ____

Preferred Contact Method: ☐ **Phone** ☐ **Fax** ☐ **Email**

Prescription Information

Pirfenidone Formulation

☐ Tablets
☐ Capsules

Testing – Please attach report documentation

☐ Forced Vital Capacity - Date of test: ____/____/____
% of predicted: _______________

☐ High-resolution CT Scan - Date of test: ____/____/____

☐ Lung Biopsy - Date of test:____/____/____

☐ Baseline Blood Tests - Date of test: ____/____/____

☐ Blood tests ordered and pending

Notes: ____

☐ **Titration Therapy x 4 weeks – Pirfenidone 267 mg dosage form**
Week 1 – Pirfenidone 267 mg three times a day with food
Week 2 – Pirfenidone 534 mg three times a day with food
Week 3 and onwards – Pirfenidone 801 mg three times a day with food

☐ **Maintenance – Pirfenidone 801 mg three times a day with food**

Other Instructions: _____________________________________

Quantity to Dispense: _____________

Repeats: ☐ 12 months
☐ Other: ________________________

Physician Signature: ____________________________________ **Date** (DD/MM/YYYY): _____/_____/______

Mar 2025

Prescriber Certification
This prescription represents the original of the prescription drug order.
The pharmacy noted above is the only intended recipient and there are no others.
The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.