Clinical Policy: Pirfenidone (Esbriet)

Reference Number: CP.PHAR.286
Effective Date: 10.01.16
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pirfenidone (Esbriet®) is a pyridone.

FDA Approved Indication(s)

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

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that pirfenidone and Esbriet are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Idiopathic Pulmonary Fibrosis (must meet all)**:**

1. Diagnosis of IPF;
2. Prescribed by or in consultation with a pulmonologist;
3. Age ≥ 18 years;
4. Member meets both of the following (a and b):
   a. Pulmonary fibrosis on high resolution computed tomography (HRCT) with one of the following (i or ii):
      i. Usual interstitial pneumonia (UIP) pattern;
      ii. Probable or indeterminate UIP pattern, and surgical lung biopsy, cellular analysis of bronchoalveolar lavage fluid, or transbronchial lung cryobiopsy confirms the diagnosis of IPF;
   b. Known causes of pulmonary fibrosis have been ruled out *(see Appendix D);*
5. Baseline forced vital capacity (FVC) ≥ 50% of predicted;
6. Baseline carbon monoxide diffusing capacity (DLCO) ≥ 30% of predicted;
7. If request is for brand Esbriet, member must use generic pirfenidone, unless contraindicated or clinically significant adverse events are experienced;
8. Esbriet is not prescribed concurrently with Ofev®;
9. Member is not an active smoker as evidenced by recent (within the last 30 days) negative nicotine metabolite (i.e., cotinine) test;
10. Dose does not exceed all of the following (a, b, and c):
    a. Days 1 through 7 (both i and ii):
       i. 801 mg per day;
       ii. 3 capsules or 3 tablets per day;

b. Days 8 through 14 (both i and ii):
   i. 1,602 mg per day;
   ii. 6 capsules or 6 tablets per day;
c. Day 15 and onward (both i and ii):
   i. 2,403 mg per day;
   ii. 9 capsules or 3 tablets per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet all)**:**

1. If request is for brand Esbriet, member must use generic pirfenidone, unless contraindicated or clinically significant adverse events are experienced;
2. One of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Idiopathic Pulmonary Fibrosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy;
3. If request is for brand Esbriet, member must use generic pirfenidone, unless contraindicated or clinically significant adverse events are experienced;
4. Esbriet is not prescribed concurrently with Ofev;

5. If request is for a dose increase, new dose does not exceed (a and b):
   a. 2,403 mg per day;
   b. 9 capsules or 3 tablets per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet all)**:**

1. If request is for brand Esbriet, member must use generic pirfenidone, unless contraindicated or clinically significant adverse events are experienced;
2. One of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DLCO: carbon monoxide diffusing capacity
FDA: Food and Drug Administration
FVC: forced vital capacity
HCRT: high resolution computed tomography
IPF: idiopathic pulmonary fibrosis
UIP: usual interstitial pneumonia

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: American Thoracic Society (ATS) 2022 IPF Guidelines

- ATS diagnostic criteria for IPF are built around pulmonary fibrosis findings on HRCT and exclusion of known causes of interstitial lung disease (e.g., domestic, and occupational environmental exposures, connective tissue disease, drug toxicity).
- UIP is the hallmark radiologic pattern of IPF. Honeycombing is a distinguishing feature of UIP and must be present for a definite HRCT diagnosis of UIP to be made.
- In patients with a probable or indeterminate UIP pattern, surgical lung biopsy, transbronchial lung cryobiopsy, or cellular analysis of bronchoalveolar lavage fluid is recommended to confirm the diagnosis of IPF. Patients with a probable UIP pattern can receive a diagnosis of IPF without confirmation by lung biopsy after multidisciplinary discussion in the appropriate clinical setting (e.g., 60 years old, male, smoker).

Appendix E: General Information

- Smoking causes decreased exposure to Esbriet, which may alter the efficacy profile of Esbriet. Instruct patients to stop smoking prior to treatment with Esbriet and to avoid smoking when using Esbriet.
- The Esbriet pivotal studies included only patients with mild to moderate lung impairment per FVC and DLCO.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IPF	Days 1 through 7: 267 mg PO TID Days 8 through 14: 534 mg PO TID Days 15 onward: 801 mg PO TID	Days 1 through 7: 801 mg/day Days 8 through 14: 1,602 mg/day Days 15 onward: 2,403 mg/day

VI. Product Availability

- Capsule: 267 mg
- Tablets: 267 mg, 534 mg*, 801 mg

**Available only as generic*

VII. References

1. Esbriet Prescribing Information. South San Francisco, CA: Genentech USA, Inc.; March 2025. Available at:www.esbriet.com. Accessed April 17, 2026.
2. Pirfenidone Prescribing Information. Berkeley Heights, NJ: Laurus Generics, Inc.; January 2025. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=29b0fd0e-5a2b-4da7-8524-177dc28bf55e. Accessed April 17, 2026.
3. Raghu G, Rochwerg B, Yuang Z, et al. An official ATS/ERS/JRS/ALAT clinical practice guideline: Treatment of idiopathic pulmonary fibrosis, an update of the 2011 clinical practice guideline. Am J Respir Crit Care Med. 2015; 192(2): e3-e19.
4. Raghu G, Collard HR, Egan JJ, et al. An official ATS/ERS/JRS/ALAT statement: Idiopathic pulmonary fibrosis: Evidence-based guidelines for diagnosis and management. Am J Respir Crit Care Med. 2011; 183: 788-824.
5. Raghu G, Remy-Jardin M, Myers JL, et al. An official ATS/ERS/JRS/ALAT clinical Practice guideline: Diagnosis of idiopathic pulmonary fibrosis. Am J Respir Crit Care Med. 2018 September; 198(5): e44-68.

6. 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): e18-47.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2022 annual review: no significant changes; references reviewed and updated.	03.30.22	08.22
RT4: added new strength of 534 mg tablet (available generically only from Laurus Generics). Per September SDC added redirection to generic tablets for brand tablet/capsule requests. Template changes applied to other diagnoses/indications and continued therapy sections.	09.26.22	
3Q 2023 annual review: added transbronchial lung cryobiopsy as an option to confirm diagnosis per 2022 ATS guidelines; references reviewed and updated.	04.18.23	08.23
3Q 2024 annual review: no significant changes; revised policy/ criteria section to also include generic pirfenidone; references reviewed and updated.	05.14.24	08.24
Per December SDC, revised generic redirection to generic tablet or capsule by removing specific formulations.	12.02.24	02.25
3Q 2025 annual review: for other indications/diagnoses, revised generic redirection to allow either tablet or capsule by removing specific formulations; references reviewed and updated.	04.29.25	08.25
3Q 2026 annual review: added ICHRA line of business; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.	04.20.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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