aetna®

Entyvio® (vedolizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Entyvio: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For ALL requests

☐ Yes ☐ No Will vedolizumab (Entyvio) be used concomitantly with aprelimast, tofacitinib, or any other biologic DMARDs (e.g., adalimumab, infliximab)?

For Crohn's Disease

Please indicate the severity of the patient's Crohn's disease: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there clinical evidence that the disease is active?

☐ Yes ☐ No Is the Crohn's disease manifested by at least one of the following?
→ Check all that apply: ☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction ☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss

☐ Yes ☐ No Has the Crohn's disease remained active despite treatment with 6-mercaptopurine or azathioprine?
→ Please provide the name and date range of the trial: Name: _____ Date range: ____/____/____ - ____/____/____

☐ Yes ☐ No Has the Crohn's disease remained active despite treatment with corticosteroids (e.g.hydrocortisone, methylprednisolone, prednisone)?
→ Please provide the name and date range of the trial: Name: _____ Date range: ____/____/____ - ____/____/____

For Ulcerative Colitis

☐ Yes ☐ No Is the patient hospitalized with fulminant ulcerative colitis?
→ Please select the symptoms the patient exhibit: ☐ more than 10 stools per day ☐ continuous bleeding ☐ abdominal pain ☐ abdominal distention ☐ acute, severe toxic symptoms, including fever and anorexia

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the severity of the patient's ulcerative colitis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

→ ☐ Yes ☐ No Does the patient require continuous immunosuppression with corticosteroids (e.g., hydrocortisone ,methylprednisolone, prednisone)?

→ Please provide the name and date range: Name: _____ Dose: _____ Date range: ____/____/____ to ____/____/____

Please indicate the route: ☐ Oral ☐ IV

☐ Yes ☐ No Is there documented evidence the patient is refractory to immunosuppression with corticosteroids?

☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) ineffective?

→ Please provide the name of the medication(s): _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Does the patient have a documented intolerance to immunosuppressive drugs (e.g., azathioprine, 6-mercaptopurine)?

☐ Yes ☐ No Does the patient have a documented contraindication to immunosuppressive drugs (e.g., azathioprine, 6-mercaptopurine)?

☐ Yes ☐ No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine,sulfasalazine) ineffective?

→ Please provide the name of the medication(s): _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Does the patient have a documented intolerance to 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine)?

☐ Yes ☐ No Does the patient have a documented contraindication to 5-aminosalicylic acid agents? (e.g., balsalazide, mesalamine, sulfasalazine)?

For Continuation requests

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of vedolizumab (Entyvio)? (Sampling of Entyvio does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.