



Entyvio® (vedolizumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Please Use Medicare Request Form

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Entyvio (vedolizumab) 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 (clinical documentation required):

Yes No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drugs (DMARD) (e.g., Xeljanz)?

Yes No Is this infusion request in an outpatient hospital setting?

Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____

Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: Cardiopulmonary: _____
 Respiratory: _____
 Renal: _____
 Other: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required):

Crohn's disease

Please indicate loading dose at weeks 0, 2, and 6: _____. Please indicate maintenance dose: _____ frequency: ____ weeks.

- Yes No Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
 - Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active Crohn's disease?
 - Yes No Does the patient have fistulizing Crohn's Disease?
 - Yes No Has the patient tried and had an inadequate response to at least one conventional therapy option?
 - Yes No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone[Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?
- Please select: Sulfasalazine (Azulfidine, Sulfazine) Metronidazole (Flagyl) Ciprofloxacin (Cipro)
 Prednisone Budesonide (Entocort EC) Azathioprine (Azasan, Imuran)
 Mercaptopurine (Purinethol) Methotrexate intramuscular (IM) or subcutaneous (SC)
 Methylprednisolone (Solu-Medrol) Rifaximin (Xifaxan) Tacrolimus

Immune checkpoint inhibitor-related diarrhea or colitis

- Yes No Has the patient experienced an inadequate response, intolerance, or contraindication to systemic corticosteroids?

Ulcerative colitis

- Yes No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
- Yes No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active ulcerative colitis?
 - Yes No Has the patient been hospitalized for acute, severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?
 - Yes No Has the patient tried and had an inadequate response to at least one conventional therapy option?
 - Yes No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazine, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?
 - Please select: Azathioprine (Azasan, Imuran) Corticosteroid (e.g., Hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
 Cyclosporine (Sandimmune) Mesalamine (e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa), balsalazine, olsalazine Mercaptopurine (Purinethol) Sulfasalazine Tacrolimus (Prograf)
 Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)

For Continuation Requests (clinical documentation required):

For Crohn's disease and Ulcerative Colitis only:

Please indicate dose: _____. Please indicate maintenance dose: _____ frequency: ____ weeks.

- Yes No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
- Yes No Has the patient achieved or maintained remission?
- Yes No Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

Crohn's disease:

Please indicate which of the following has the patient experienced:

- Abdominal pain or tenderness Abdominal mass Body weight Diarrhea Endoscopic appearance of the mucosa Hematocrit
- Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) None of the above

Ulcerative Colitis:

Please indicate which of the following has the patient experienced:

- Stool frequency Rectal bleeding Urgency of defecation C-reactive protein (CRP) Fecal calprotectin (FC) Endoscopic appearance of the mucosa Improvement on a disease activity scoring tool (e.g., Ulcerative colitis Endoscopic Index of Severity [UCEIS], Mayo score) None of the above

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.