



MEDICARE FORM

Entyvio® (vedolizumab) Injectable Medication Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Entyvio is preferred on MA plans. On MAPD plans Entyvio is preferred for ulcerative colitis and non-preferred for Crohn's disease.

Please indicate: [] Start of treatment: Start date ___/___/___ [] Continuation of therapy: Date of last treatment ___/___/___

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, DOB, Allergies, Email, Current Weight, Height.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Does patient have other coverage?, If yes, provide ID#, Carrier Name, Insured.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name, Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Fields include Place of Administration (Self-administered, Physician's Office, Outpatient Infusion Center, Home Infusion Center, Administration code(s)), Address, Dispensing Provider/Pharmacy (Physician's Office, Retail Pharmacy, Specialty Pharmacy, Mail Order, Other), Name, Address, Phone, Fax, TIN, NPI.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for Entyvio (vedolizumab): Dose, Frequency, HCPCS Code.

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

Form section F: Diagnosis Information. Fields include 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 Initiation Requests (clinical documentation required):

Note: Entyvio is preferred on MA plans. On MAPD plans, Entyvio is preferred for ulcerative colitis and non-preferred for Crohn's disease. The preferred product for Crohn's disease is Humira.

[] Yes [] No Has the patient had prior therapy with Entyvio (vedolizumab) within the last 365 days?

[] Yes [] No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any other medical reason(s) that the patient cannot use Humira (adalimumab).

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

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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.

Crohn's Disease

Does the patient have a diagnosis of fistulizing Crohn's disease? If yes, please indicate the date of the diagnosis: ___/___/___
Please indicate the severity of the patient's Crohn's disease: Mild Moderate Severe
Is there clinical evidence that the disease is active?
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
Was treatment with corticosteroids ineffective?
Was treatment with corticosteroids not tolerated or contraindicated?
Which of the following corticosteroids was tried? hydrocortisone methylprednisolone prednisone Other: Please explain:
Was treatment with 6-mercaptopurine (6-MP) ineffective?
Was treatment with 6-mercaptopurine (6-MP) not tolerated or contraindicated?
Was treatment with azathioprine ineffective?
Was treatment with azathioprine not tolerated or contraindicated?

Ulcerative Colitis

Is the patient hospitalized fulminant ulcerative colitis?
Please indicate the severity of the patient's ulcerative colitis: Mild Moderate Severe
Is there evidence that the disease is active?
Is the patient refractory to immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?
Does the patient require continuous immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?
Name and dose: Name: Dose:
Please indicate the route: Oral IV
Was treatment with immunosuppressant agent (e.g., azathioprine, m6-mercaptopurine) ineffective?
Was treatment with immunosuppressant agent (e.g., azathioprine, m6-mercaptopurine) not tolerated or contraindicated?
Provide the name of the drug(s):
Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) ineffective?
Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) not tolerated or contraindicated?
Provide the name of the drug(s):
Please select the symptoms the patient exhibit: more than 10 stools per day continuous bleeding abdominal pain distension acute, severe toxic symptoms, including fever and anorexia

For Continuation requests (clinical documentation required):

Will Entyvio (vedolizumab) be used concomitantly with aprelimast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
Is this continuation request a result of the patient receiving samples of Entyvio (vedolizumab)?
Is there clinical documentation supporting disease stability?
Is there clinical documentation supporting disease improvement?
Has the patient received Entyvio (vedolizumab) within the past 6 months?
Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
Could the adverse reaction be managed through pre-medication in the home or office setting?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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.