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# MEDICARE FORM

# Entyvio® (vedolizumab) Injectable Medication Precertification Request



(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 non preferred. Renflexis is preferred for MA plans Humira is preferred for MAPD plans.**

**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: _____

## 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: |
| Office Contact Name: | | | | Phone: | |

## 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:**
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Entyvio (vedolizumab): Dose:** _____ **Frequency:** _____ **HCPCS Code:** _____

## 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 Initiation Requests (clinical documentation required):**

**Note: Entyvio is non preferred. Renflexis is preferred for MA plans and Humira is preferred for MAPD plans.**

☐ 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 Renflexis (infliximab-abda)?
☐ 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 Renflexis (infliximab-abda).

_____

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)?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient medically unstable for infusions at alternate levels of care?
☐ Yes ☐ No Does the patient have a history of any cardiopulmonary conditions?
→ Please provide the description of the condition: _____
☐ Yes ☐ No Does this condition cause an increased risk of severe adverse reactions?
☐ Yes ☐ No Does the patient have documentation of unstable vascular access?
☐ Yes ☐ No Does the patient have physical or cognitive impairments such that home infusion would present an unnecessary health risk?
→ Please explain: _____
☐ Yes ☐ No Is there clinical evidence that the patient has an inability to safely tolerate intravenous volume load (including from unstable renal function)?
→ ☐ Yes ☐ No Is the inability to tolerate intravenous volume load due to unstable renal function?
→ Please document the following:
☐ GFR:____ mL/min/1.73m$^2$ Date Collected: ____/____/____
☐ BUN:____ mg/dL Date Collected: ____/____/____
☐ Creatinine:____ mg/dL Date Collected: ____/____/____



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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**

☐ Yes ☐ No 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

☐ 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 Was treatment with corticosteroids ineffective?

→ ☐ Yes ☐ No Was treatment with corticosteroids not tolerated or contraindicated?

→ ☐ not tolerated ☐ contraindicated

→ Which of the following corticosteroids was tried? ☐ hydrocortisone ☐ methylprednisolone ☐ prednisone ☐ Other: Please explain: _____

→ Which of the following corticosteroids was tried? ☐ hydrocortisone ☐ methylprednisolone ☐ prednisone ☐ Other: Please explain: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was treatment with 6-mercaptopurine (6-MP) ineffective?

→ ☐ Yes ☐ No Was treatment with 6-mercaptopurine (6-MP) not tolerated or contraindicated?

→ ☐ not tolerated ☐ contraindicated

→ Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was treatment with azathioprine ineffective?

→ ☐ Yes ☐ No Was treatment with azathioprine not tolerated or contraindicated?

→ ☐ not tolerated ☐ contraindicated

→ Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**Ulcerative Colitis**

☐ Yes ☐ No Is the patient hospitalized fulminant ulcerative colitis?

→ 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 Is the patient refractory to immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?

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

→ Name and dose: Name: _____ Dose: _____

Please indicate the route: ☐ Oral ☐ IV

Length of time on therapy: ☐ 1- 10 days ☐ 10 to 29 days ☐ 30 days or greater

→ Name and dose: Name: _____ Dose: _____

Please indicate the route: ☐ Oral ☐ IV

Length of time on therapy: ☐ 1- 10 days ☐ 10 to 29 days ☐ 30 days or greater

☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, m6-mercaptopurine) ineffective?

→ ☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, m6-mercaptopurine) not tolerated or contraindicated?

→ ☐ not tolerated ☐ contraindicated

→ Provide the name of the drug(s): _____

→ Provide the name of the drug(s): _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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

→ ☐ Yes ☐ No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) not tolerated or contraindicated?

→ ☐ not tolerated ☐ contraindicated

→ Provide the name of the drug(s): _____

→ Provide the name of the drug(s): _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

→ 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

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|---|---|---|---|
| | | | |

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

**For Continuation requests (clinical documentation required):**

- ☐ Yes ☐ No Will Entyvio (vedolizumab) be used concomitantly with aprelimast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
- ☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Entyvio (vedolizumab)?
- ☐ Yes ☐ No Is there clinical documentation supporting disease stability?
- ☐ Yes ☐ No Is there clinical documentation supporting disease improvement?
- ☐ Yes ☐ No Has the patient received Entyvio (vedolizumab) within the past 6 months?
  - → ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life threatening adverse event that occurred during or following the previous infusion?
    - → ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

**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.