univera HEALTHCARE

Specialty Medication Review Program

Entyvio (vedolizumab)® **IV**
For Crohn's Disease **OR** Ulcerative Colitis
Medical Benefit

Complete this form and fax to: If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

Medical Specialty Unit
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

☐ **Noble**
Fax: 1-888-842-3977
Phone: 1-888-843-2040

Complete all the following Patient/Physician information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ Prescriber office ☐ Home/Homecare agency:_____
☐ Outpatient facility ☐ Other: _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	Dose	Frequency	Height	Weight (lbs./kg)	Procedure Code
Entyvio IV (J3380)	**300mg/ vial**	☐ **Loading Dose**: 300 mg IV at 0,2, and 6 weeks; then 300 mg IV q 8 weeks thereafter ☐ **Maintenance Dose**: 300 mg IV given ____ weeks			

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (Recertification) Start date: _____

Questions/Indications for Medical Necessity

**** See the Inflammatory CRPA Policy (Pharmacy-73) for full Prior Authorization criteria ****

Select One of The Following Diagnoses:

☐ Active Moderate to severe ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____

Crohn's Disease ***** Please Provide Recent Progress Notes *****

1. Has the diagnosis of moderate to severe active Crohn's disease been made by a gastroenterologist? ☐ **Yes** ☐ **No**
2. Is the patient currently experiencing disease flare? ☐ **Yes** ☐ **No**
3. Has the patient had a failure or intolerance to any of the following? (*Check all that apply)

☐ Methotrexate From_____To _____
☐ Azathioprine From_____To _____
☐ Mercaptopurine From_____To _____
☐ Other From_____To _____

Ulcerative Colitis ***** Please Provide Recent Progress Notes *****

1. Has the diagnosis of Ulcerative Colitis been made by a gastroenterologist? ☐ **Yes** ☐ **No**
2. Has the patient had failure or intolerance to at **least ONE** of the agents listed below?

☐ Thiopurines (azathioprine, mercaptopurine)
☐ 5-Aminosalicylates (sulfasalazine, mesalamine, olsalazine)
☐ Cyclosporine
☐ IV or oral steroids

*Prescriber Signature: _____ Date: _____
I certify the above information is true and accurate to the best of my knowledge.