PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Entyvio (vedolizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is Entyvio being prescribed for (pick one)?

- ☐ Moderate to severe ulcerative colitis
- ☐ Moderate to severe Crohn's disease
- ☐ Other

Q2. Please provide ICD diagnosis code.

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

Q4. Is the prescriber a gastroenterologist?

☐ Yes ☐ No

Q5. Does the patient have failure of an adequate trial of any of the following anti-TNF agents? Please check all that apply.

- ☐ Cimzia
- ☐ Humira
- ☐ Remicade or Renflexis

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

- ☐ Simponi
- ☐ Other (please specify)
- ☐ None

Q6. Does the patient have clinically significant intolerance or contraindication to any of the following anti-TNF agents? Please check all that apply.

- ☐ Cimzia
- ☐ Humira
- ☐ Remicade or Renflexis
- ☐ Simponi
- ☐ Other (please specify)
- ☐ None

Q7. Does the patient have history of progressive multifocal leukoencephalopathy (PML)?

☐ Yes ☐ No

Q8. Does the patient have history of other slow-virus infection [e.g. subacute sclerosing panencephalitis (SSPE), progressive rubella panencephalitis (PRP), HIV, AIDS, rabies]?

☐ Yes ☐ No

Q9. Does the patient have history of a medical condition that significantly compromises the immune system (e.g. leukemia, organ transplant)?

☐ Yes ☐ No

Q10. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q11. Provide name and NPI of the billing entity

Q12. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Medical	☐ Pharmacy
Q13. Additional Comments	

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.