EntyvioSQ (vedolizumab) Prior Authorization Request Form Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____

MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

MEMBER INFORMATION			
LAST NAME:	FIRST NAME	:	
PHONE NUMBER:	DATE OF BIR	RTH:	
STREET ADDRESS:	I		
CITY:	STATE:	ZIP CODE:	
PATIENT INSURANCE ID NUMBER:			

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER. YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE

FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): ______

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE: ZIP CODE:	
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL	DISPENSING INFORMATION		
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
NEW THERAPY DURATION OF THERAPY (SPE	RENEWAL CIFIC DATES):	IF RENEWAL: DATE THERAPY	INITIATED:

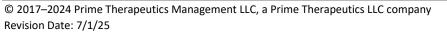
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHER	MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR		
	•	FAILURE/ALLERGY:		
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGT:		
2. LIST DIAGNOSES:		ICD-10:		
Ulcerative colitis(UC)				
Crohn's Disease(CD)				
Other diagnosis:	ICD-10			
Code(s):				
3. REQUIRED CLINICAL INFORMATION:	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
PRIOR AUTHORIZATION.				
Is patient going to be using drug	in a clinical trial? 🛛 Yes 🛛 No			
Initial Request:				
	ware when the exiting the N	- Diagon automit abort		
	evere ulcerative colitis? Yes N	o Please submit chart		
documentation.				
Does patient have Crohn's Diseas	Se? 🗆 Yes 🗆 No			
la procoribar a gastrooptarologist				
Is prescriber a gastroenterologist				
Is prescriber a rheumatologist? Yes No				
	maintenance therapy ONLY (NOT I	NDUCTION THERAPY- medical)?		
□ Yes □ No				
	st one of the following three therap			
and/or 6-mercaptopurine?	No Please submit chart docume	ntation.		
Has nationt triad and failed at loss	t one of the following: dupocortics	id therapy or methotroyate or		
Has patient tried and failed at least one of the following: glucocorticoid therapy or methotrexate or				
azathioprine or 6-mercaptopurine and/or 5-ASA/mesalamine? Yes No Please submit chart				
documentation.				
Use notions tried and failed at least three menths with the biasimilar for Uumire, adelimumah as f				
Has patient tried and failed at least three months with the biosimilar for Humira, adalimumab-aacf				
product? Yes No Please sub	omit chart documentation.			
Does patient have an absolute contraindication to the biosimilar adalimumab-aacf? \square Yes \square No				
Please submit chart documentation.				
Has the patient tried and had an inadequate response to a 4-month trial of the biosimilar for Stelara,				
Otulfi(usekinumab-aauz)?				
Does patient have a absolute contraindication to the biosimilar for Stelara, Otulfi(usekinumab-aauz)?				
☐ Yes ☐ No (Please submit documentation)				
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Will patient use drug in combination with another biologic response modifier or immunomodulatory agent? Quad Yes Quad No		
If so, will that biologic response modifier or immunomodulatory agent be discontinued when		
Entyvio(vedolizumab) is started? Ves No		
<u>Renewal Request</u> :		
Is patient continuing to demonstrate a positive clincial response? Yes No Please submit chart documentation.		
Is prescriber a gastroenterologist? Yes No		
Is prescriber a rheumatologist? Yes No		
Will patient use drug in combination with another biologic response modifier or immunomodulatory		
agent? □ Yes □ No		
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?		
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that		
the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical		
information necessary to verify the accuracy of the information reported on this form.		
Prescriber Signature or Electronic I.D. Verification: Date: Date:		

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201 P.O. Box 64811 St. Paul, MN 55164-0811 Phone: 877-228-7909

