PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Entyvio® (vedolizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Entyvio 300 mg vial

Dose:_____ **Dose Frequency**:_____

Start date: _____

Date of last dose: _____

Date of next dose: _____

Height: _____ **Weight**: _____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered for an initial 14-week therapy, the patient must meet all of the following requirements:

1. Patient must be age 18 or older
2. Must have one of the following diagnoses and meet applicable step therapy requirements:
   a. Moderate to severe Crohn's disease, requires ALL of the following:
      - Patient has *moderate to severe Crohn's disease*, defined by at least one of the following :
        - Age at initial diagnosis < 30 years
        - Extensive anatomic involvement

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2019

Last reviewed 03/2019

- Perianal and/or severe disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior

▪ Patient has prior use of corticosteroids
▪ Must first try infliximab

b. Mild Crohn's disease
▪ Must first try one of the following: corticosteroids, mesalamine, olsalazine, sulfasalazine, azathioprine, 6-MP, or methotrexate
▪ Must first try infliximab

c. Severe ulcerative colitis
▪ Patient has frequent loose bloody stools (≥6 per day) with severe cramps and evidence of systemic toxicity
▪ Patient has prior use of corticosteroids
▪ Must first try infliximab

d. Mild to moderate ulcerative colitis
▪ Must first try two of the following: 6-mercaptopurine (6-MP), azathioprine, balsalazide, corticosteroids, mesalamine, and sulfasalazine
▪ Must first try infliximab

3. Documented negative TB test result every 12 months

FOR CONTINUATION, PATIENT MUST MEET THE FOLLOWING REQUIREMENTS EVERY TWO YEARS
1. Must be compliant in taking the medication as prescribed
2. Must tolerate the medication
3. Must not experience any severe adverse reactions while taking the medication
4. Must have documentation of response to treatment
5. Must have a negative TB test result in the previous 12 months

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

What is the date and result of the patient's most recent TB test?
☐ Negative ☐ Positive Date: _____

A. What condition is this drug being requested for?

☐ Moderate to severe Crohn's disease

1. Which, if any, of the following apply to the patient?
☐ Less than age 30 at his or her initial diagnosis
☐ Extensive anatomic involvement
☐ Perianal and/or severe disease
☐ Deep ulcers
☐ Prior surgical resection
☐ Stricturing and/or penetrating behavior

☐ None of the above

2. Has the patient tried corticosteroids? ☐ Yes ☐ No

3. Has the patient tried infliximab? ☐ Yes ☐ No

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☐ Mild Crohn's disease

1. **Which of the following drugs has the patient tried?**
   - ☐ Corticosteroids
   - ☐ Olsalazine
   - ☐ Azathioprine
   - ☐ Methotrexate
   - ☐ Mesalamine
   - ☐ Sulfasalazine
   - ☐ 6-mercaptopurine
2. **Has the patient tried infliximab?** ☐ Yes ☐ No

☐ Severe ulcerative colitis

1. **Does the patient have frequent loose bloody stools (≥6 per day) with severe cramps?** ☐ Yes ☐ No
2. **Does the patient have systemic toxicity?** ☐ Yes ☐ No
3. **Has the patient tried corticosteroids?** ☐ Yes ☐ No
4. **Has the patient tried infliximab?** ☐ Yes ☐ No

☐ Mild ulcerative colitis

1. **Which of the following drugs has the patient tried?**
   - ☐ 6-mercaptopurine
   - ☐ Balsalazide
   - ☐ Mesalamine
   - ☐ Azathioprine
   - ☐ Corticosteroids
   - ☐ Sulfasalazine
2. **Has the patient tried infliximab?** ☐ Yes ☐ No

Continuation request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Other, the patient's condition is: _____

B. Select all of the following that apply to this patient:

- ☐ The patient is compliant in taking the medication as scheduled
- ☐ The patient tolerated the medication
- ☐ The patient did not experience any adverse reactions while taking the medication
- ☐ The patient has responded to treatment *(documentation has been provided)*
- ☐ The patient had a *negative* TB test result in the previous 12 months. *Date of TB test:* _____

Additional information

Dosing is limited to 300 mg given at weeks 0, 2, and 6, and then every 8 weeks thereafter.

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