aetna®

MEDICARE FORM

Entyvio® (vedolizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Entyvio is non-preferred. Preferred products vary based on indication.
See section G below.

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. Remicade and Renflexis are preferred for MA plans. For MAPD plans, Humira is preferred for Crohn's disease and Remicade and Renflexis are preferred for ulcerative colitis.

☐ 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 Remicade (infliximab) or 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 Remicade (infliximab) or 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)?

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

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
Name and dose: Name: _____ Dose: _____
→ Please indicate the route: ☐ Oral ☐ IV
☐ 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): _____
☐ 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 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

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?

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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.