

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Entyvio (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.

When conditions are met, we will authorize the coverage of Entyvio (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Entyvio (vedolizumab)

Other, please specify _____

Quantity _____

Frequency _____

Strength _____

Route of Administration _____

Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____

NPI Number: _____

Physician Fax: _____

Physician Phone: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized Entyvio in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

[If no, skip to question 3.]

2. Is the patient in remission without requiring more than 5mg of prednisone daily? Y N

[No further questions.]

3. Does the patient have a diagnosis of Crohn's Disease? Y N

[If no, skip to question 8.]

4. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone dosed at 40mg or more per day after 30 days? Y N

[If yes, skip to question 16.]

5. Does the patient have steroid-dependent Crohn's disease as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N

[If no, then no further questions.]

6. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA), mercaptopurine (6-mp) or injectable methotrexate? Y N

[If yes, skip to question 16.]

7. Does the patient have a contraindication to all of the following: azathioprine (AZA), injectable methotrexate and mercaptopurine (6-MP)? Y N

If yes, please document contraindication(s):

[If yes, skip to question 16.]

[If no, then no further questions]

8. Does the patient have a diagnosis of ulcerative colitis (UC)? Y N

[If no, then no further questions.]

9. Has the patient had inadequate response or intolerable side effects to IV corticosteroids after 7-10 days or oral prednisone (dosed at 40mg or more per day for 30 days)? Y N

[If no, skip to question 13.]

10. Has the patient had a previous treatment failure with azathioprine (AZA) AND mercaptopurine (6-MP) OR has a contraindication to azathioprine and mercaptopurine? Y N

If yes, please list medication tried and/or contraindications:_____

[If yes, skip to question 16.]

11. Has the patient had surgery for ulcerative colitis (UC)? Y N
 [If yes, skip to question 16.]
12. Has the patient failed a trial of cyclosporine OR has a contraindication to cyclosporine? Y N
 List contraindication(s) if applicable:

 [If no, then no further questions.]
 [If yes, skip to question 16.]
13. Does the patient have steroid-dependent ulcerative colitis as evidenced by one of the following: A) Patient had a relapse within three months of stopping corticosteroids; OR B) Patient is unable to taper steroids to an acceptable dose after 3 months without having symptom recurrence? Y N
 [If no, then no further questions.]
14. Has the patient had failure to an adequate trial (3 months) of azathioprine (AZA) or mercaptopurine (6-MP)? Y N
 [If yes, skip to question 16.]
15. Does the patient have a contraindication to azathioprine and mercaptopurine? Y N
 If yes, please indicate which contraindication(s):

 [If no, then no further questions]
16. Has the patient had a trial and failure of at least one formulary anti-TNF (tumor necrosis factor inhibitor)? Y N
 [If no, then no further questions.]
17. Is the patient at least 18 years of age? Y N
 [If no, then no further questions.]
18. Is Entyvio being prescribed by, or in consultation with a gastroenterologist? Y N
 [If no, then no further questions.]

19. Will Entyvio be given in combination with any antineoplastic, immunosuppressive, or immunomodulating agents (e.g., azathioprine, 6-mercaptopurine, cyclosporine, methotrexate, anti-TNFs)?

Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature

Date