Entyvio® (vedolizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

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:
Provider Email:	Office Contact Name:		Phone:		

Specialty *(Check one):* ☐ **Gastroenterologist** ☐ **Other**: _____

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: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Entyvio (vedolizumab) Dose: _____ **Frequency:** _____

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 All Requests (clinical documentation required):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drugs (e.g., Xeljanz)?

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

- ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
- ☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
- ☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
  → Please provide a description of the behavioral issue or impairment: _____
- ☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
  → Please provide a description of the condition:
  ☐ Cardiopulmonary: _____
  ☐ Respiratory: _____
  ☐ Renal: _____
  ☐ Other: _____

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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.

For Initiation Requests (clinical documentation required):

Crohn's disease

Please indicate loading dose at weeks 0, 2, and 6: _____. Please indicate maintenance dose: _____ frequency: _____ weeks.

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active or fistulizing Crohn's disease (CD)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease?

→ ☐ Yes ☐ No Does the patient have fistulizing Crohn's Disease?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone[Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)?

→ Please select: ☐ Sulfasalazine (Azulfidine, Sulfazine) ☐ Metronidazole (Flagyl) ☐ Ciprofloxacin (Cipro) ☐ Prednisone ☐ Budesonide (Entocort EC) ☐ Azathioprine (Azasan, Imuran) ☐ Mercaptopurine (Purinethol) ☐ Methotrexate intramuscular (IM) or subcutaneous (SC) ☐ Methylprednisolone (Solu-Medrol) ☐ Rifaximin (Xifaxan) ☐ Tacrolimus

Immune checkpoint inhibitor-related diarrhea or colitis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?

☐ Yes ☐ No Has the patient experienced an inadequate response to systemic corticosteroids?

☐ Yes ☐ No Does the patient have a contraindication to systemic corticosteroids?

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

Ulcerative colitis

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active ulcerative colitis?

→ ☐ Yes ☐ No Has the patient been hospitalized for acute, severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)?

→ ☐ Yes ☐ No Has the patient tried and had an inadequate response to at least one conventional therapy option?

→ ☐ Yes ☐ No Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., hydrocortisone (Cortifoam, Colocort, Solu-Cortef, Cortef), methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazine, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf])?

→ Please select: ☐ Azathioprine (Azasan, Imuran) ☐ Corticosteroid (e.g., Hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone) ☐ Cyclosporine (Sandimmune) ☐ Mesalamine (e.g., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa), balsalazide, olsalazine ☐ Mercaptopurine (Purinethol) ☐ Sulfasalazine ☐ Tacrolimus (Prograf)

For Continuation Requests (clinical documentation required):

For Crohn's disease and Ulcerative Colitis only:

Please indicate dose: _____. Please indicate maintenance dose: _____ frequency: _____ weeks.

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient achieved or maintained remission?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

Crohn's disease:

Please indicate which of the following has the patient experienced:

☐ Abdominal pain or tenderness ☐ Abdominal mass ☐ Body weight ☐ Diarrhea ☐ Endoscopic appearance of the mucosa ☐ Hematocrit ☐ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ☐ None of the above

Ulcerative Colitis:

Please indicate which of the following has the patient experienced:

☐ Stool frequency ☐ Rectal bleeding ☐ Urgency of defecation ☐ C-reactive protein (CRP) ☐ Fecal calprotectin (FC) ☐ Endoscopic appearance of the mucosa ☐ Improvement on a disease activity scoring tool (e.g., Ulcerative colitis Endoscopic Index of Severity [UCEIS], Mayo score) ☐ None of the above

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.