



**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.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Ulcerative colitis(UC) <input type="checkbox"/> Crohn's Disease(CD) <input type="checkbox"/> Other diagnosis: _____		ICD-10: ICD-10 Code(s): _____
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Is patient going to be using drug in a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Initial Request:</p> <p>Does patient have moderate-to-severe ulcerative colitis? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>Does patient have Crohn's Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is prescriber a gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is prescriber a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is this request for subcutaneous maintenance therapy ONLY (NOT INDUCTION THERAPY- medical)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine and/or 6-mercaptopurine? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>Has patient tried and failed at least three months with the biosimilar for Humira, adalimumab-aacf product? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>Has patient tried and failed at least three months with Humira(adalimumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>Does patient have an absolute contraindication to Humira or adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit chart documentation.</p> <p>Will patient use drug in combination with another biologic response modifier or immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, will that biologic response modifier or immunomodulatory agent be discontinued when Entyvio(vedolizumab) is started? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Renewal Request:</p>		





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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Is patient continuing to demonstrate a positive clinical 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:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program Attn:CP-4201

P.O.Box 64811

St. Paul, MN 55164-0811

Phone: 877-228-7909

