

ENTYVIO (Non-Preferred)
PRIOR AUTHORIZATION FORM

Entyvio is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Cytokine & CAM Antagonists (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office Contact Name: _____ Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (_____) _____

MEDICAL INFORMATION

Dose: _____ Quantity: _____ Refills: _____ Currently receiving Entyvio therapy

Diagnosis: _____ Diagnosis Code: _____ (Required)

Specialist Type: Gastroenterologist Other: _____

Which Specialty Pharmacy will be utilized? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

Please check all that apply to the Recipient and submit documentation

- Screened for Tuberculosis
- Screened for Hepatitis B (antibody and/or surface antigen)
- Up-to-date with immunizations (If less than 21 years old, in accordance with EPSDT guidelines)

INITIAL REQUEST:

Check all that apply to the Recipient and submit documentation

1. Does the Recipient have any signs of jaundice or elevated LFTs? Yes No
2. Document baseline liver function tests (LFTs): AST: _____ ALT: _____ Serum Bilirubin: _____
3. Has the recipient ever taken Tysabri (natalizumab)? Yes No

Crohn's Disease & Ulcerative Colitis: Check all that apply to the Recipient and submit documentation

Has the Recipient tried & failed (or have a contraindication or intolerance to) any of the following:

- Humira Aminosalicylates (ex. mesalamine, sulfasalazine) Corticosteroids
- Immunomodulators (ex. 6-mercaptopurine, azathioprine)

Other Indications: *Submit clinical documentation of diagnosis, supporting medical literature, and therapies that have been tried*

ALL RENEWAL REQUESTS:

1. Has the Recipient had an improvement in his/her condition and/or level of functioning (**submit documentation**): Yes No
2. **Submit documentation** of follow-up liver function tests (LFTs): AST: _____ ALT: _____ Serum Bilirubin: _____

PLEASE FAX COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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