pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ENTYVIO (vedolizumab) (non-preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Entyvio are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Cytokine & CAM Antagonists** and **Quantity Limits/Daily Dose Limits** accessible at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: **Entyvio (vedolizumab)** ☐300 mg vial ☐_____	**Quantity**: _____ vials	**Refills**:
Directions:		
Diagnosis (submit documentation):	**Dx code** (*required*):	
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty		

Initial request		
1. Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐up-to-date with all age-appropriate immunizations ☐screened for hepatitis B (surface antigen & core antibody) ☐screened for tuberculosis		
2. Does the beneficiary have results of baseline testing for the following? *Check all that apply.* ☐ anti-JC virus antibodies ☐liver function tests (LFTs)	☐Yes ☐No	*Submit test results.*
3. Does the beneficiary have signs of jaundice or elevated transaminases or bilirubin?	☐Yes ☐No	*Submit documentation.*
4. Did the beneficiary ever take Tysabri (natalizumab)?	☐Yes ☐No	*Submit documentation.*
5. ***Crohn's disease or ulcerative colitis:*** Does the beneficiary have a history of trial and failure of, or contraindication or intolerance to, the following medications? *Check all that apply.* ☐aminosalicylates (eg, mesalamine, sulfasalazine) ☐corticosteroids (eg, prednisone) ☐immune modulators (eg, azathioprine, methotrexate, 6-mercaptopurine) ☐TNF-alpha inhibitors (eg, Cimzia, Humira, Simponi)	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Crohn's disease:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent, **Humira?**	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
7. ***Ulcerative colitis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents, **Humira** and **Xeljanz**?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
8. ***For a diagnosis other than the approved indication(s),*** submit documentation supporting the use of the requested medication for the beneficiary's diagnosis & other treatments tried.		

Renewal request		
1. Since starting Entyvio, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*
2. Does the beneficiary have results of follow-up liver function tests since starting Entyvio?	☐Yes ☐No	*Submit test results.*
3. ***If baseline testing for anti-JC virus antibodies was negative***, does the beneficiary have results of repeat testing since starting Entyvio?	☐Yes ☐No	*Submit test results.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: